



STUDY AND PLAN FOR MAXIMIZING FEDERAL MEDICAID FUNDS FOR HAWAII

Prepared By

**Lewin/ICF
and
Fox Health Policy Consultants**

A Report to the Governor and the Legislature of the State of Hawaii

LEWIN/ICF
A Health & Sciences International Company

1090 Vermont Avenue, N.W.
Suite 700
Washington, D.C. 20005
(202) 842-2800

FOX, INC.
Health Policy Consultants

1140 Connecticut Avenue, N.W.
Suite 1205
Washington, D.C. 20036
(202) 223-1500

**STUDY AND PLAN
FOR MAXIMIZING FEDERAL MEDICAID
FUNDS FOR HAWAII**



Prepared by

**Lewin/ICF
and
Fox Health Policy Consultants**

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

**Legislative Auditor of the State of Hawaii
Honolulu, Hawaii**

February 1990

TABLE OF CONTENTS

<i>Chapter</i>		<i>Page</i>
	EXECUTIVE SUMMARY	ix
1	STUDY BACKGROUND AND DESIGN	1
	Introduction	1
	Impetus for the Study	1
	Purpose and Scope of the Study	3
	Approach and Data Sources	4
	Overview of the Hawaii Medicaid Program	4
	Organization of the Report	8
2	MEDICAID BENEFIT AND BILLING OPTIONS	11
	Introduction	11
	Overview of DOH Services and Current Medicaid Coverage	12
	Potential Benefit and Billing Options for Maximizing Hawaii’s Federal Medicaid Revenue	16
	Assessment and Recommendation of Options	64
3	ELIGIBILITY AND ENROLLMENT OPTIONS	67
	Introduction	67
	Current Medicaid Eligibility in Hawaii	67
	Opportunities for Enhanced Eligibility and Enrollment	72
	Assessment of the Options	81
	Coordination Issues for SHIP and Medicaid	90
	Recommendations	91
4	ADMINISTRATIVE ASSESSMENT	95
	Introduction	95
	Overview of Relevant Agencies	96
	Efforts to Maximize Federal Dollars	99
	Ongoing Capacity to Respond to Opportunities	101
	Recommendations	107

<i>Chapter</i>		<i>Page</i>
5	STRATEGIC PLAN	111
	Additional Issues for Study	111
	Strategic Plan Action Steps	112
	NOTES	121

<i>Appendix</i>		<i>Page</i>
A	Enrollment Trends in the Hawaii Medicaid Program ..	125
B	Required and Optional Services Under the Federal/ State Medicaid Program	129
C	Cost and Caseload Estimate Methodology for Medicaid Eligibility Expansion	133
D	Summary of Previous Estimates of the Uninsured in Hawaii	137
E	Administrative Recommendations Considered and Rejected During the Course of This Study	139
	GLOSSARY OF ABBREVIATIONS AND TERMS ...	141
	RESPONSES OF THE AFFECTED AGENCIES	143

LIST OF EXHIBITS

<i>Exhibit</i>		<i>Page</i>
1.1	Major Eligibility Groups for Federal/State Medicaid in Hawaii, January 1990	7
2.1	Summary of Major Recommendations for Medicaid Coverage of DOH Programs	13

<i>Exhibit</i>		<i>Page</i>
2.2	Department of Health Organization Chart	14
3.1	Summary of Recommendations for Medicaid Eligibility Expansion	68
3.2	Medicaid and the Poor in Hawaii (Income Levels for a Family of Four in 1989)	69
3.3	Recent Expansions in the Hawaii Federal/State Medicaid Program	73
3.4	Medicaid and the Poor in Hawaii (Income Levels for a Family of Four in 1989)	74
3.5	Caseload and Cost Estimates for Medicaid Eligibility Expansions, Hawaii, FY 1990-91	75
3.6	Pregnant Women and Infants Enrolled in New Federal/State Medicaid-Only Categories in Hawaii, January-November 1989	78
3.7	Estimated Savings in State Dollars by Use of Medicaid Expansions Versus SHIP Assuming Varying Per Capita Costs for SHIP	85
3.8	Percent Distribution of Recipients and Expenditures by Category, Hawaii Federal/State Medicaid Program, Fiscal Year 1988-89	88
3.9	Medicaid Cost Increases by Population Category, Hawaii and the U.S., 1984-1988	89
4.1	Department of Human Services Organization Chart ..	97
4.2	Department of Health Organization Chart	100
A.1	Medicaid Enrollment, Unemployment, and Changes in the AFDS Payment Standard	126
A.2	Trends in Hawaii Medicaid Enrollment, Selected Eligibility Groups, July 1985-October 1989	128

AN EXECUTIVE SUMMARY OF THE STUDY AND PLAN FOR MAXIMIZING FEDERAL MEDICAID FUNDS FOR HAWAII

The *Study And Plan For Maximizing Federal Medicaid Funds For Hawaii* was prepared under contract with the legislative auditor by the health policy consulting firms of Lewin/ICF and Fox Health Policy Consultants. The Hawaii State Legislature requested the study and plan of the auditor during its 1989 Regular Session under House Concurrent Resolution No. 256 and Senate Concurrent Resolution No. 214.

The study focused on maximizing federal Medicaid funds *through expanded Medicaid coverage of services and populations which are currently state funded*. The potential for this expanded Medicaid coverage was found in the programs of the Department of Health (DOH). Consequently, we assessed two types of Medicaid options in light of DOH programs: (1) benefit and billing options relative to DOH provided medical and health care services, and (2) eligibility and enrollment options relative to the coverage of medically indigent persons under DOH's new State Health Insurance Program (SHIP). We also assessed the capacity of the Department of Human Services, the agency responsible for the administration of the Hawaii Medicaid program, to keep abreast of opportunities to maximize federal Medicaid dollars.

The Medicaid Program

Medicaid is a nationwide federal/state health care coverage program for selected low-income populations. The Medicaid program is established by Title XIX of the Social Security Act, under the jurisdiction of the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (DHHS). The federal government establishes and enforces regulations and guidelines for the Medicaid program. The states administer their Medicaid programs within this framework. Beyond the federally required core program consisting of certain benefits and population coverage, states may choose to cover other optional benefits and populations specified by federal law. States have considerable flexibility in formulating eligibility, benefits, and reimbursement policies. The federal government and the states fund the program jointly. The federal government provides *matching funds at a rate based on per capita income*, which in Hawaii is now about 54 percent.

In Hawaii, the term "Medicaid" is used by DHS to refer to *two* programs: (1) the jointly funded *federal/state Medicaid* program, and (2) a *medical assistance program funded solely by the State*

that is primarily for adults who qualify for Hawaii's *General Assistance* (GA) program. Except for the difference in their source of funding, these two programs are administered generally as one.

Medicaid Benefit and Billing Options

Examination of DOH service programs showed that there is a significant potential for greater Medicaid coverage and reimbursements for a number of DOH services. Although only rough estimating was possible given available data, it appears that approximately \$2 million, or more, could be obtained by Hawaii if it adopted recommended changes.

There are a number of limitations in Hawaii Medicaid policy that have the effect of excluding DOH services or limiting Medicaid reimbursements. Currently, the Hawaii Medicaid program does not include a benefit that is critically important to DOH programs; it defines too narrowly some existing benefits; and it reimburses DOH at rates that do not maximize federal revenue. Also, DOH providers often do not bill the Medicaid program for services that are already reimbursable.

Therefore, it is recommended that Hawaii:

1. Adopt a targeted case management benefit under Medicaid to cover the care coordination services provided by DOH to a number of medically complex, developmentally disabled, mentally ill, and other high risk populations;
2. Under Hawaii's existing Medicaid ancillary therapy benefits, permit Medicaid coverage of occupational therapy and physical therapy services provided by DOH to special education students;
3. Expand its Medicaid definition of rehabilitation services to permit coverage of mental health services to students with emotional problems and to adults with severe emotional disability;
4. Adopt Medicaid coverage for certain public health nursing services under the independent licensed practitioner benefit;
5. Increase its Medicaid reimbursement rate for clinic services to reflect the actual DOH service costs; and
6. Require DOH providers of service to bill Medicaid for all Medicaid-reimbursable services.

These recommendations would affect 14 services in five DOH program areas: family health, developmental disabilities, community health nursing, adult mental health services, and children and adolescent mental health services.

The major cost to the State in adopting these options would be the commitment of resources that would be needed to effect the recommended changes. Each of the recommended actions carries with it a number of major tasks that would require staff time and other resources. Another potential cost, which is extremely difficult to anticipate, is the possibility of expanded utilization of services that may occur with the broadening of Medicaid coverage to include DOH services. In addition, with some of the recommendations regarding services it is possible that some non-DOH providers would want to participate.

Eligibility and Enrollment Options

The Hawaii Medicaid program currently covers most optional eligibility categories for which federal reimbursement is available. Those remaining were assessed for their potential to maximize federal financing in the State's efforts to insure health care coverage and adequate access for uninsured "gap groups." Based on this assessment, Hawaii should expand Medicaid eligibility in accordance with the following recommendations.

1. Eligibility should be expanded to include all children age 4 to 8 up to the poverty level.

This option will help cover an important gap group--dependents of low wage workers--and it will help reduce the number of low-income uninsured in the State. It is also likely to be a more cost-effective way of covering selected gap group populations than the SHIP program by drawing on federal dollars to pay more than one-half of total costs.¹

2. The Medicaid income eligibility standard should be raised to the maximum allowed under federal law where it would not incur additional welfare expenditures.

Currently set at the AFDC (Aid to Families with Dependent Children) Payment Standard, this threshold should be raised to 133-1/3 percent of the Payment Standard for all family sizes. This will cover another portion of the low-income uninsured, particularly those with incomes slightly higher than the welfare standard but still too low to make health insurance affordable. This option is also likely to be a more cost-effective form of coverage than that of SHIP because of the federal Medicaid match.

¹At the conclusion of this study, the U.S. Congress mandated coverage (as of April 1, 1990) of a new population group in the Omnibus Budget Reconciliation Act (OBRA) of 1989: pregnant women and children up to age 6 with family incomes up to 133 percent of poverty. Thus the optional group of below-poverty children analyzed for this report has become mandatory for children age 4 to 6.

3. Efforts should be undertaken to enhance enrollment in existing and future Medicaid-only eligibility categories.

Aggressive enrollment efforts can help Hawaii reduce the number of uninsured in the State, and help ensure adequate and timely access for low-income populations. This is particularly important for such target groups as pregnant women, for whom postponement of primary health care increases the chances of low birthweight and the need for expensive hospital care. Moreover, Medicaid coverage at income levels higher than current welfare levels can help the near-poor with the transition from welfare dependency to self-sufficiency.

Specifically, efforts to enhance enrollment should include: (a) the use of a short form for enrolling those interested only in Medicaid and not other forms of assistance, (b) the placement of out-stationed enrollment workers in DOH clinics and other similar settings, and (c) continued recruitment of providers who qualify to enroll pregnant women on an early and preliminary basis.

4. Steps should be taken to ensure that SHIP is well coordinated with Medicaid.

The study brought to light the need to develop close coordination between the Medicaid and SHIP programs if the State's efforts to provide medical coverage to the indigent are to be fully effective. This would require close collaboration between DOH and DHS to assure Medicaid is utilized first where possible, to provide and facilitate continuity of coverage, and to provide access to health care providers in both programs. There should be coordination in the following ways:

- a unified or coordinated eligibility process that will allow for efficient eligibility assessment and facilitate enrollment shifts between the two programs;
- an accessible and straightforward eligibility process for the two programs;
- open enrollments under SHIP for persons who lose Medicaid;
- a process for changing enrollment as eligibility status changes;
- mechanisms for assuring use of Medicaid as the preferred coverage where possible; and
- fair and equitable provider reimbursements in the two programs to avoid disrupting provider participation in either program.

Administrative Assessment

The study highlighted the *shared responsibilities of two major state agencies*, DOH and DHS, not only for the issue of Medicaid maximization but also for the State's overall effort to provide medical coverage for the indigent. Examination showed that both agencies need to further develop mechanisms that will allow them to work individually and collaboratively to effectively identify

and pursue opportunities for federal reimbursement. These changes require specific actions on the part of the two agencies but also require a more fundamental change between them--*a recognition of their mutual objectives and responsibilities and the need to truly work together.*

While some effort has already been made by both agencies to improve coordination, more is needed. Problems remain, including: (1) lack of a focal point for coordination within DHS and its need to improve monitoring and use of available data systems, (2) an insufficient central planning capacity within DOH, (3) insufficient coordination between the two departments, and (4) inadequate communication with other parties interested in Medicaid.

To improve the situation, the following recommendations are made.

1. DHS and DOH should each establish an internal coordinating body for addressing Medicaid issues.
2. An interagency Task Force should be created to effect improved interdepartmental communication and coordination relative to expanding utilization of federal Medicaid dollars and to other state health initiatives involving the two departments.
3. Both departments should make clear on a department-wide basis the State's desire that they seek input from all parties interested in the Medicaid program, and should establish a focal point and clear channels for input.
4. Each Department should establish information systems that will provide necessary data for effective assessments, monitoring, and evaluation of specific Medicaid options, and the overall extent of Medicaid coverage in the State of Hawaii.
5. DHS should be directed to make timely assessments of new Medicaid eligibility and financing options as they become available, reporting to the Legislature on recommendations to adopt or not.

With these five recommendations in place, Hawaii will be well equipped to maximize federal dollars in its health programs.

Strategic Plan

The preceding recommendations are incorporated into a Strategic Plan for Hawaii for maximizing federal Medicaid funding. The plan sets forth the actions that have to be taken to implement the recommendations within suggested time frames.

Along with the Strategic Plan, this report presents six critical issues that are outside the scope of this study but which the State should also examine. When combined with the specific action

steps in the Strategic Plan, these additional efforts would contribute to a truly comprehensive effort to make optimal use of federal Medicaid dollars in pursuit of statewide health policy goals.

Chapter 1

STUDY BACKGROUND AND DESIGN

Introduction

This report assesses and recommends options for maximizing federal dollars in the Hawaii State Medicaid program. Medicaid is the major public health insurance program for low-income populations. The report presents state Medicaid program changes in two areas that will result in additional federal revenues: benefit and billing structures, and changes in eligibility. The report also makes recommendations for administrative changes in the Department of Human Services (DHS) and the Department of Health (DOH) that will support the state's efforts to maximize federal dollars in pursuing state health policy goals. Authorization of the study came from House Concurrent Resolution 256 and Senate Concurrent Resolution 214 of the 1989 legislative session.

This chapter reviews factors leading to the need for this study, the purpose and scope as defined by the authorizing legislation, methodologies used to conduct the work, and overall organization of the report. This chapter also provides an overview of the Medicaid program in Hawaii.

Impetus for the Study

A number of developments in Hawaii prompted this study. First, there has long been a recognition that some state dollars currently spent on programs for the poor and uninsured could be replaced by federal Medicaid dollars. Medicaid is financed in Hawaii, as elsewhere, with both federal and state dollars, with the federal government covering approximately 54 percent of total costs. Many other health programs for the poor, however, are financed entirely with state dollars. To the extent there are persons or services in these state programs that could be covered by Medicaid, current state expenditures could be replaced at a 54 percent rate by federal dollars. This would allow for a savings or reprogramming of current state expenditures. Similarly, block grant and other federal funds now used to finance health services could be reprogrammed to alternative uses if the affected services were financed through Medicaid.

Second, there has been a trend toward increasing eligibility for Medicaid in Hawaii, but there has been little systematic analysis of remaining eligibility options available to the State or of the effectiveness of those that have been implemented. In January of 1989, for instance, the State began to cover all pregnant women and infants with family incomes up to the poverty level, and

in January of 1990 the income level was raised again to 185 percent of poverty for this group, but little is known about the results of these expansions.

Finally, there has been increasing interest in Hawaii in providing health insurance for the low-income uninsured. Debate on this issue culminated with the passage of the State Health Insurance Program (SHIP) in Act 378, Session Laws of Hawaii 1989. This act required the Department of Health (DOH) to provide basic health insurance coverage for persons under 200 percent of poverty, an action that is now being planned for implementation during 1990. The passage of SHIP increased the importance of this study. Some of the persons to be covered by SHIP could be potentially covered through expanded Medicaid eligibility instead, thereby taking advantage of available federal dollars.

Hawaii is unique among the states in that only about 5 to 9 percent of the population is uninsured, compared to rates of 8 to 19 percent in other states.¹ This is largely because the Hawaii Prepaid Health Care Act of 1974 requires most employers to provide health insurance to their employees. Still uninsured, however, are several "gap groups" unaffected by the employer requirement. These groups generally include persons with incomes too high to qualify for Medicaid, but too low to purchase a non-group insurance policy. The major "gap groups" include:²

- . Part-time workers and their families who are excluded from the Prepaid Health Care Act provisions if they work less than 20 hours per week.
- . Self-employed persons, seasonal workers, and students, all of whom are not covered by the Prepaid Health Care Act provisions.
- . Spouses in single worker, low-income families (especially women) for whom coverage by employers is not required and for whom family coverage may be unaffordable to the breadwinner.
- . Children in low-income families also for whom coverage by employers is not required and for whom dependent coverage may be unaffordable to the breadwinner.
- . Unemployed persons and their families.
- . Immigrants, including undocumented aliens, who are often in one of the above groups and may not qualify for Medicaid regardless of their income.

To the extent these remaining gap groups can be covered by Medicaid, the state can finance their coverage with a 54 percent federal match, compared to the state-only expenditures planned under the SHIP initiative.

Purpose and Scope of the Study

Three objectives were specified by the Legislature for this study:

- . To identify, evaluate, and recommend for adoption options available to the State under the federal Medicaid program that are currently not included in or fully utilized by the Hawaii Medicaid program.
- . To evaluate the capacity of the Hawaii Medicaid program's administration to keep abreast of and effectively respond to ongoing changes to the federal Medicaid program and new opportunities to maximize federal dollars.
- . To formulate a strategic plan for the State to maximize recovery of federal dollars from Medicaid.

Given the limited time and resources and the size and complexity of the Medicaid program, the scope of the study was directed toward examining basic program changes that would most readily obtain tangible results for the State. Consequently, the study focused on maximizing federal Medicaid funds through expansion of coverage of the Medicaid program to services and populations *that are currently state-funded*. In this context, the study sought to identify federal Medicaid benefit and eligibility options which are currently not utilized by Hawaii and state services that are potentially medically eligible. This was found to involve primarily the programs of DOH. Thus, *benefit options* were assessed in light of existing services provided by DOH, and *eligibility options* were evaluated relative to the coverage of persons intended under DOH's new State Health Insurance Program. In addition, DOH's billing practices for its service programs were reviewed to determine if existing Medicaid coverage is being fully utilized. Further, the analysis of eligibility options included an examination of the potential for improving the effectiveness of Hawaii's Medicaid coverage through increased efforts at enrolling Medicaid eligible persons.

Not all of the options considered would necessarily result in the reduction or reallocation of existing state expenditures. In some cases, the options would increase coverage of the uninsured in Hawaii. Here the potential for exchange of federal dollars for state dollars are less clear. Some options may result in a net increase in state spending for medical care, but there may also be commensurate decreases in state spending for other assistance programs or in private sector subsidization of indigent medical care.

The examination of Medicaid administrative issues was also necessarily limited to the primary question of the State's ability to monitor and respond adequately to opportunities to maximize federal Medicaid dollars. This aspect of the study involved two major agencies of the State: DHS and DOH. DHS was examined as the state agency responsible for administering Medicaid in

Hawaii. DOH was reviewed as the State's lead agency for health, as a provider of medical and health services, and as the administrator of the new State Health Insurance Program.

Although the study attempted to address all major issues falling within its scope, it could not examine thoroughly all of the details of implementation that will be required. This may necessitate further analysis. Further, the study did not assess the efficiency and effectiveness of the current Medicaid program or its administration, nor did it attempt to be a comprehensive study of Medicaid in Hawaii. However, it did recommend where study of these broader issues may be important for the State. Thus, given the particular focus of this study, it remains for the State to weigh the recommendations of this report in the broader context of its overall Medicaid policy and refine or adjust them as necessary.

Approach and Data Sources

A combination of data sources was used to conduct this study. Telephone and in-person interviews were conducted with staff in DOH, DHS, and a range of other organizations, both public and private, in Hawaii and nationally. Existing documentation from the two agencies was also reviewed, and a series of requests were made for special data. We also used federal law, regulation, and guidelines; studies on Medicaid programs; and other data relevant to Medicaid. The U.S. Census Bureau's Current Population Survey (CPS) was utilized as the basic data for estimating of the number of persons potentially eligible for Medicaid coverage options. (See Appendix C for discussion of the CPS methodology.)

Overview of the Hawaii Medicaid Program

Medicaid is a nation-wide federal/state health care coverage program for selected low-income populations. The federal government and the states fund the program jointly, with the federal government providing matching funds at a rate based on state per capita income. The Medicaid program was established in 1965 as Title XIX of the Social Security Act under the general jurisdiction of the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (DHHS). While the federal government establishes and enforces regulations and guidelines for the program (documented in Title 42 of the U.S. *Code of Federal Regulations* (CFR), parts 430-456), states administer Medicaid and have considerable flexibility in formulating eligibility, benefits, and reimbursement policies within the boundaries set by the federal law.

In Hawaii, the term “Medicaid” encompasses two programs:

- . Federal/state Medicaid refers to the program established by Title XIX of the Social Security Act, and is jointly funded by the federal government and Hawaii.
- . State-only Medicaid refers to the program of medical assistance to low-income persons who cannot qualify for Medicaid under federal rules. This program is funded solely by Hawaii. It is comprised primarily of adults who receive cash assistance through the Hawaii General Assistance (GA) program which is also funded entirely by the State.

Except for the difference in their source of funding, these two components are administered generally as one program. The difference in financing is handled through the Hawaii Medicaid Management Information System (MMIS), which identifies program participants by their eligibility status and assures proper billing so that federal reimbursement is received when appropriate.

In Hawaii, the federal government pays 54 percent of federal/state Medicaid costs for most health services and 50 percent of federal/state Medicaid for most administrative costs. This study was prompted by the potential to obtain this federal match for persons and services that might otherwise be supported at full state cost.

Eligibility under the federal/state Medicaid program. Until recently, eligibility for federal/state Medicaid was linked by federal law almost exclusively to eligibility for federally aided cash assistance, including the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. These programs, in turn, have been linked to family composition and other demographic factors known as “categorical requirements.” Thus, for example, only families with a single or unemployed parent can obtain AFDC, and only if their income is below a state-established threshold that is far below the poverty level in Hawaii and most other states. Medicaid eligibility was in turn linked primarily (although not exclusively) to eligibility for AFDC.

Successive changes in federal law--some of them recent and some of them longstanding--have changed this. There are now several groups, many of them optional to the states, that can obtain federal/state Medicaid coverage without being eligible for federally aided cash assistance. This allows states to provide additional medical coverage *without* increasing state expense for cash assistance. Moreover, the targeted nature of these groups allows states to focus on particularly vulnerable groups such as pregnant women and children. Many of the new groups are *working poor* populations who have incomes too high to qualify for AFDC or Medicaid under the traditional income thresholds.

In Hawaii, the major groups covered by federal/state Medicaid are shown in Exhibit 1.1. The chart makes the distinction between the groups that can obtain both federally aided *cash assistance* and *Medicaid* and those that are eligible for *Medicaid only*. Also shown are the groups for whom coverage by states is *mandatory* under federal law, and those for whom coverage is *optional*.

the Medically Needy. These are persons who would be eligible for categorical coverage but have incomes that are too high. They can qualify for Medicaid if their income is no more than the AFDC payment standard after their medical expenses are subtracted. This process of subtracting incurred medical bills from gross income is called "spenddown." Hawaii has the option, which it has not taken, of raising the Medically Needy income standard higher than it is now.

Eligibility under the state-only Medicaid program. In addition to the groups in the federal/state Medicaid program, Hawaii has chosen to offer medical assistance to persons who do not meet federal categorical requirements. State-only Medicaid is offered primarily in conjunction with the state's General Assistance (GA) cash program. As noted above, state-only Medicaid is financed entirely by the state, although it uses the same income thresholds as federal/state Medicaid (and AFDC) and offers the same benefits. State-only Medicaid (and GA) is available to:

- . single adults who are incapacitated;
- . childless couples, in which at least one member is incapacitated; and,
- . parents in intact families that do not qualify as "unemployed."

These groups cannot qualify for federal/state Medicaid regardless of their income.

Enrollment trends. In Hawaii Fiscal Year 1989, the Hawaii Medicaid program (including both federal/state and state-only) had an average monthly enrollment of approximately 67,600. This represents the first year since 1978 that there has not been a decline in persons covered by the program. Enrollment peaked in 1978 at 95,600. While the factors contributing to declining enrollment are not always clear, several developments have played a role:

- . The federal government tightened eligibility rules for AFDC--and thus for federal/state Medicaid--in the early 1980s.
- . Unemployment in Hawaii declined from 6.7 percent in 1982 to a rate of less than 3 percent in the latter half of 1989.
- . Medicaid income eligibility levels have not kept pace with inflation in Hawaii. Between 1978 and 1983, the AFDC payment standard--a major determinant of income eligibility--remained fixed at \$468 per month for a family of three.

Between Fiscal Year 1987-88 and Fiscal Year 1988-89, enrollment in Medicaid increased by about 1,200 persons. In part, this was because Hawaii raised the AFDC payment standard during this time. In addition, new eligibility groups were added to the program as discussed in Chapter 3. More detailed discussion of enrollment trends appears in Appendix A.

Exhibit 1.1

Major Eligibility for Federal/State Medicaid in Hawaii
January 1990

ELIGIBLE FOR CASH ASSISTANCE AND MEDICAID

ELIGIBLE FOR MEDICAID ONLY

MANDATORY (REQUIRED BY FEDERAL LAW)

- Aged, blind, and disabled who meet income and resource standards for Supplemental Security Income (SSI).¹
- Single-parent families (i.e., one parent is absent from the home, incapacitated, or deceased) that meet state income and resource standards for Aid to Families with Dependent Children (AFDC).

- Pregnant women and infants with family income up to the poverty level, regardless of family composition.
- Children with family incomes up to the state AFDC income and resource standards, regardless of family composition. (This is primarily children in two-parent families. Federal law requires coverage of children up to age 8; Hawaii covers up to age 18. Many of the children can obtain cash assistance through the state-financed General Assistance program.)

OPTIONAL (ELIGIBLE FOR FEDERAL MATCH AT STATE'S OPTION)

- Two-parent families in which the principal breadwinner is unemployed, and that meet state income and resource standards for Aid to Families with Dependent Children (AFDC Unemployed Parent Program).²

- Aged, blind, and disabled with incomes up to the poverty level, and who meet state resource standards (some of this group can also obtain cash assistance).³
- Pregnant women and infants with family incomes up to 185 percent of the poverty level, regardless of family composition.⁴
- Children up to age four with family incomes up to the poverty level, regardless of family composition.⁴ (Hawaii can raise the age cutoff to age eight.)
- Medically Needy persons or persons in any of the other categories with a family income higher than the AFDC payment standard, but with sufficient medical expenses to "spend down" to that level.

NOTE: This is a simplified description of Medicaid eligibility in Hawaii and does not include all eligibility categories.

Source: Hawaii Medicaid state plan.

1. Hawaii has retained the option to be more restrictive than SSI income standards for Medicaid eligibility under authority of 209(b) of Title XIX; the state has not, however, generally used this authority in determining eligibility.
2. This cash and medical option will become mandatory for states in 1990 in response to the federal Family Support Act.
3. The federal Medicare Catastrophic Coverage Act requires states to cover Medicare copayments and deductibles for elderly and disabled persons up to poverty (called "Qualified Medicare Beneficiaries"), a provision which covers more than the persons in this optional group because of a higher resource standard.
4. At the completion of this study, the federal Omnibus Budget Reconciliation Act (OBRA) of 1989 was passed, mandating coverage of pregnant women, infants, and children up to age 6 living in families with incomes up to 133 percent of poverty. This requirement is scheduled to be effective April 1, 1990.

Medicaid benefits. States are required by federal law to provide a number of specific basic services under the federal/state Medicaid program. In addition, they can cover a number of optional services. The required benefits and the optional services provided by Hawaii are described in detail in Appendix B.

Under the federal/state program, states may offer fewer optional services to the Medically Needy. Hawaii, however, has chosen to provide the same set of services to the Medically Needy as to other eligible groups.

States may also apply certain limitations in amount, duration, and scope of services provided in federal/state Medicaid to all or selected eligibility groups. These limitations include annual limits on the number of physician visits or days of hospitalization that will be reimbursed under the program. Hawaii, however, has imposed no major limitations in these areas.

Services under state-only Medicaid in Hawaii are the same as for the federal/state program. This determination is not governed or affected by federal regulation.

Administration. Federal law requires that a single state agency be designated as the administrator of federal/state Medicaid. In Hawaii, the Department of Human Services (DHS) through its Health Care Administration Division (HCAD) operates the Medicaid program. DHS contracts with the Hawaii Medical Service Association (HMSA) to manage claims processing and payment. The division and its contract agent and their functions are described in more detail in Chapter 4.

The key guiding documents of the program at the state level are the Medicaid State Plan and the state administrative rules (Chapters 742-769, Subtitle 6 of Hawaii Administrative Rules). These compilations are revised and updated periodically when changes occur in federal or state regulations of the program. Changes in the State Plan must be reviewed and approved by HCFA for the State to be considered in compliance with federal regulations and eligible for federal matching funds.

Program costs. Total Fiscal Year 1988-89 expenditures for federal/state and state-only Medicaid in Hawaii were \$214.6 million. Approximately \$86 million of the amount were federal funds.

Organization of the Report

The remainder of this report is organized as follows:

- Chapter 2, Benefit and Billing Options, describes and assesses options available to Hawaii for maximizing federal Medicaid revenue by revising its Medicaid policies on covered services relative to services provided by DOH. Recommendations are also offered regarding billing by DOH to Medicaid for currently reimbursable services.

- . Chapter 3, Eligibility and Enrollment Options, reviews and assesses Hawaii's options for expanding Medicaid eligibility. It also examines approaches for increasing enrollment of persons who are eligible for Medicaid but have not registered for the program. Also included are recommendations for ensuring adequate coordination between Medicaid and SHIP.
- . Chapter 4, Administrative Assessment, presents our findings on the capacity of DHS and DOH to identify, assess, and implement options for expanded Medicaid financing in the context of broader state health policy. The chapter recommends new mechanisms that will help the two agencies implement and monitor recommendations from the preceding two chapters, as well as future financing opportunities.
- . Chapter 5, Strategic Plan, summarizes our recommendations in the form of action steps and a timetable for tapping into new federal Medicaid dollars.

Chapter 2

MEDICAID BENEFIT AND BILLING OPTIONS

Introduction

This chapter describes and assesses options available to Hawaii for maximizing federal Medicaid revenue by revising its Medicaid policies on covered services. It focuses on services that are currently provided by the Department of Health (DOH) and funded with state dollars. To the extent these services can be covered by Medicaid, 54 percent of these state dollars could be replaced with federal funding. The options include the addition of a new benefit category, the revision of existing categories, the authorization of higher reimbursement rates, and also requirements for mandatory billing of Medicaid-reimbursable services.

In examining Hawaii's Medicaid state plan to determine the extent to which reimbursement would be available for DOH-funded services, we found several limitations in current coverage policy:

- . One critical benefit, targeted case management, was not offered;
- . Other benefits--rehabilitative services, ancillary therapist services, and other licensed practitioner services--were defined too narrowly to include some services needed by certain DOH target populations; and
- . One widely available benefit, clinic services, was reimbursed by Medicaid at rates that often appeared not to cover the actual cost of the service.

In addition, we found evidence that DOH providers often did not bill the Medicaid program for currently reimbursable services. We, therefore, are recommending that Hawaii:

- . Adopt Medicaid's targeted case management benefit to cover care coordination services furnished to a number of medically complex, developmentally disabled, mentally ill, and other high-risk populations served by DOH programs;
- . Permit Medicaid coverage of occupational therapy and physical therapy services delivered to special education students under Hawaii's existing Medicaid ancillary therapy benefit;
- . Expand its Medicaid definition of rehabilitation services to permit coverage of mental health services to students with emotional problems and to adults with severe emotional disability;
- . Adopt Medicaid coverage of certain public health nursing services under the independent licensed practitioner benefit;

- . Increase its Medicaid reimbursement rate for clinic services to reflect the actual DOH service costs; and
- . Require DOH providers of services to bill Medicaid for all Medicaid-reimbursable services.

These recommendations and estimates of potential revenues are summarized in Exhibit 2.1. Although only rough estimates were possible given available data, it appears that *approximately \$2 million or more*, could be obtained by Hawaii if it adopted our recommended changes.

The rest of this chapter is divided into three sections. The first section presents a brief overview of DOH and its current Medicaid coverage policies. The second section describes the Medicaid benefit and billing options that potentially could cover DOH services, the specific DOH services affected, and the policy options available for each DOH service for which state dollars could be saved, and includes a discussion of implementation issues. The last section provides an assessment of the potential benefits and costs of implementing these options and concludes with our final recommendations.

Overview of DOH Services and Current Medicaid Coverage

The Hawaii Department of Health (DOH) is charged with advocating and facilitating the delivery of health care services to the public. The department also is to provide leadership for both public and private sector efforts to develop a coordinated health care system in Hawaii. To these ends, DOH has become involved in areas as diverse as environmental health management, services for the developmentally disabled, and dental health services.

The department recently was reorganized into six “administrations,” each headed by a deputy director as shown in Exhibit 2.2. Four of the administrations are involved in funding the direct delivery of health care services.

- . The Personal Health Services Administration, which is comprised of the Family Health Services Division, the Developmental Disabilities Division, the Community Health Nursing Division, and the Office of Health Services for the Aging (scheduled for fiscal year 1990-91);
- . The Health Promotion and Disease Prevention Administration, which is comprised of the Health Promotion and Education Division, the Communicable Disease Division, and the Dental Health Division;
- . The Behavioral Health Services Administration, comprised of the Adult Mental Health Division, the Children and Adolescent Mental Health Division, and the Alcohol/Drug Abuse Division; and

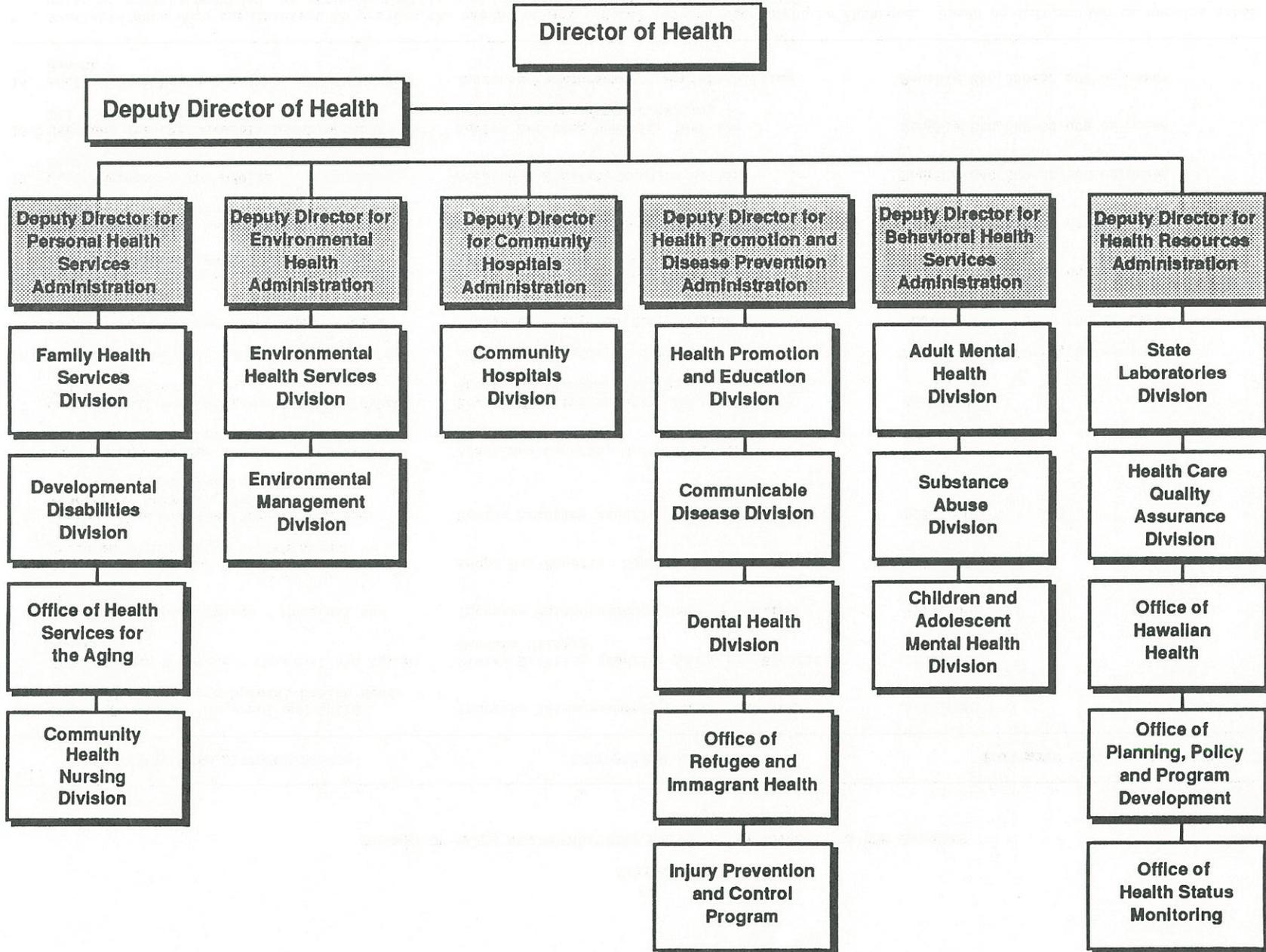
Exhibit 2.1

SUMMARY OF MAJOR RECOMMENDATIONS FOR MEDICAID COVERAGE OF DOH PROGRAMS

DOH SERVICE AND DIVISION/BRANCH	RECOMMENDED ACTION(S)	ESTIMATED NEW FEDERAL REVENUE
1. Clinic Services - Maternal and Child Health/Children with Special Health Needs	Increase Reimbursement; Mandate Billing	\$ 47,600
2. Home Visitor Services - Maternal and Child Health	Revise Existing Benefit; Adopt New Benefit; Mandate Billing	\$900,000
3. Family Planning Services - Maternal and Child Health	Increase Reimbursement; Mandate Billing	\$171,300
4. Case Management for Early Intervention - Children with Special Health Needs	Adopt New Benefit; Mandate Billing	\$ 48,200
5. Center-based Services for Infants and Toddlers - Community Services for the Developmentally Disabled	Revise Existing Benefit; Mandate Billing	\$151,200
6. Case Management for Adults - Community Services for the Developmentally Disabled	Adopt New Benefit; Mandate Billing	\$321,300
7. Occupational and Physical Therapy - School Health Services	Revise Existing Benefit; Revise DOH/DOE Agreement; Mandate Billing	\$131,200
8. Care Coordination - Public Health Nursing	Adopt New Benefit; Mandate Billing	Roughly \$40,000-50,000 or more*
9. Patient Training and Education - Public Health Nursing	Revise Existing Benefit; Mandate Billing	Roughly \$40,000-50,000 or more*
10. School-based Services - Children's and Adolescent Mental Health	Revise Existing Benefit; Revise DOH/DOE Agreement; Mandate Billing	Roughly \$40,000-50,000 or more*
11. Children's Center-based Services - Children's and Adolescent Mental Health	Increase Reimbursement; Mandate Billing	Roughly \$40,000-50,000 or more*
12. Case Management for Adults - Adult Mental Health	Adopt New Benefit; Mandate Billing	Roughly \$40,000-50,000 or more*
13. Services for the Severely Disabled Mentally Ill - Adult Mental Health	Revise Existing Benefit; Increase Reimbursement; Mandate Billing	Roughly \$40,000-50,000 or more*
14. Adult Center-based Services - Adult Mental Health	Increase Reimbursement; Mandate Billing	Roughly \$40,000-50,000 or more*

* Available data were insufficient to project the amount of new federal revenue that might be obtained. Based on information on service costs and units of service provided, we estimate that it would be roughly at least \$40,000-50,000.

DEPARTMENT OF HEALTH ORGANIZATION CHART



. The Community Hospitals Administration, comprised of the Community Hospitals Division.

Several of the divisions are further broken down into branches, each having responsibility for specific populations or services.

Selection of DOH services for analysis. A primary purpose of this study was to identify the DOH programs that could generate federal revenue if Medicaid benefit and billing policies were adopted or expanded. We limited our analysis, however, to 14 services operated by five DOH divisions because we were able to determine that these services would have a significant positive financial impact for the state. We did not include services that we believed would generate less than roughly \$40,000 - \$50,000 per year in new federal funds. Nor did we include the State Health Insurance Program in this part of the study as it did not have a defined benefit package at the time of our study.

We arrived at our rough estimates of the potential federal revenue that might be available for each service on the basis of a two-step analysis. First, we examined all of the ambulatory care services provided by DOH based on information we received from DOH and included only those services that we judged would have the biggest “pay-offs” in new federal revenue. Then, on the basis of field interviews with program staff, we further refined our selection using information on current billing practices, service costs, and number of potential Medicaid-enrolled clients.

DOH funding mechanisms. The services we chose to examine are supported by DOH in two ways. Most are furnished directly by state employees at DOH-operated facilities throughout the state. The remainder are provided by private agencies or individual practitioners funded by the State to serve DOH clients. With the exception of adult mental health services, all of the private agencies used by the DOH branches and divisions that we studied are non-profit entities.

DOH funds are awarded to private agencies in the form of grants, subsidies, or purchase of service contracts. While DOH increasingly has been negotiating purchase-of-service contracts with these agencies, it is the policy of all but one of the branches and divisions we examined to pay the private agencies at their full cost. Funding may be slightly less *if* DOH funds “run short” and the private agency has access to charitable contributions or other forms of financial support. The only branch that deviates from this policy is the Community Services for the Developmentally Disabled Branch in its funding of early intervention services.

Medicaid revenue for DOH-funded programs. Currently, there is relatively limited use of Medicaid reimbursement for DOH-funded services.¹ Some services provided at the various types of DOH clinics are reimbursed under the Medicaid benefit categories of physician services and clinic services. Non-clinic services, however, basically are not now reimbursed, despite the fact that federal Medicaid law would permit their coverage. In some instances the Hawaii Medicaid

plan includes a benefit category that could be used, but treatment services for DOH client groups--such as special education students or the developmentally disabled--cannot be billed to Medicaid because coverage policies are too narrow.

Options for state financing of Medicaid benefit and billing expansions. Hawaii is in a position to take full advantage of federal Medicaid revenue opportunities for DOH-funded services because the necessary state matching funds already are available in the DOH budget. However, reallocation of funds from DOH to the Medicaid program is not a simple matter due in part to the many private providers in DOH programs. If funds from DOH's current budget are to be reallocated to the Medicaid program, careful consideration must be given to each of these funding relationships. Any reallocation mechanisms developed should not disrupt the flow of services to the public or the ability of all providers to function effectively. Decisions on reallocation also need to involve DHS to assure sufficient reallocation of funds, compliance with federal regulations, and workable and effective interface with the Medicaid program's claims processing system.

The Legislature also needs to decide on the extent to which new federal Medicaid revenues will be used for the enhancement and expansion of DOH services (e.g., serving more persons) versus a reduction in state spending. The flow of Medicaid dollars through the State can be structured so that DOH receives none, some, or all of the new federal revenues.

Potential Benefit and Billing Options for Maximizing Hawaii's Federal Medicaid Revenue

Maximizing federal revenue through expansions or revisions in the state Medicaid plan requires a basic familiarity with federal coverage policy. Although the federal Medicaid program is very flexible--providing for numerous benefit categories and reimbursement arrangements--various issues need to be taken into account in structuring Medicaid coverage for DOH-funded services.

Policy and implementation issues. Regardless of whether a benefit category is mandatory or optional, states are free to set their own policies regarding the nature and extent of services that they will cover and the exact amount that will be reimbursed. Hawaii needs to use this flexibility to assure that any new or revised benefits are structured in such a way as to maximize federal revenue for services currently funded by DOH while leaving Medicaid expenditures for other services essentially unchanged. This objective can be achieved, for the most part, through appropriate service definition, provider qualifications, and reimbursement rates. It also requires that effective billing procedures be in place.

Service definition. The nature and purpose of the Medicaid benefit must be matched as closely as possible to the DOH service and target population. This needs to be reflected in medical necessity criteria, which are used to restrict access to the benefit to patients with only certain types of needs or characteristics, and also in utilization control procedures, which are used to assure the appropriateness of reimbursement on a case-by-case basis. Utilization control procedures include both prior authorization and utilization review.²

The federal Health Care Financing Administration (HCFA) expressly permits states to limit the amount, duration, and scope of all federal Medicaid services based on such criteria as medical necessity or on utilization review procedures. It requires only that a state's Medicaid benefit be sufficient to achieve the purpose of the service.³ In addition, for mandatory services, HCFA prohibits states from denying or reducing the amount, duration, or scope of the benefit to an otherwise eligible recipient solely because of a diagnosis, type of illness, or condition.⁴

Although the states have significant leeway in defining the nature and purpose of their Medicaid services, particularly their optional services, they are precluded from limiting the *population* of potential beneficiaries for a particular service in any manner not consistent with the defined purpose and scope of the service. HCFA's comparability requirement stipulates that a state Medicaid plan must provide that the services be available to all categorically needy recipients in equal amount, duration, and scope.⁵

In developing new or revised Medicaid definitions to cover services currently funded by DOH, the Hawaii Medicaid program would need to minimize the potential for Medicaid recipients who are not DOH clients to access these services by carefully defining the purpose and scope of the service itself. It could, for example, describe a service intended to address certain types of emotional problems, provided in accordance with a DOH prior-authorized plan of care and developed by a multidisciplinary team that included certain kinds of expertise. It could not, however, directly reference a particular DOH population as, for example, by specifying mental health services for special education students or students with IEPs (individualized education plans).

Provider participation. Provider qualifications or standards for each benefit need to be crafted so as to limit reimbursement, to the extent possible, to providers supported by DOH funds. Federal Medicaid law requires that provider qualifications not be arbitrary; they must be reasonably related to the provider's ability to furnish the service defined. Hawaii law requires that regulations pertaining to provider licensure and certification be justified by a need to protect the public⁶ and also limits DOH's regulatory authority to certain health care providers.⁷ To confine Medicaid reimbursement for specific services to DOH-funded providers, therefore, Hawaii's Medicaid program would have to rely on carefully constructed Medicaid provider standards. These could

address such qualifications as a provider agency's length of experience in the field, formal coordination and referral agreements with DOH-network providers, and capacity for appropriate supervision and training. They also could address the qualifications of individual staff, including, for example, specific education and training requirements, length of experience in the field, completion of certain kinds of continuing education courses, and familiarity with community resources and program benefits.

Medicaid provider standards in and of themselves cannot assure that only DOH-funded providers are able to receive Medicaid reimbursement. Non-DOH providers, however, can be substantially precluded from billing Medicaid by medical necessity criteria that cannot be met by their patient populations and by reimbursement rates that meet only a portion of their usual and customary costs (UCR).

Reimbursement rates. Medicaid reimbursement rates for services furnished by DOH-funded providers should reflect the actual DOH cost of delivering the services--assuming that the providers are operating efficiently. If rates are set lower than cost, then state grant or contract funds must be used by providers not only to finance care for the uninsured, but to subsidize payments for services reimbursed by Medicaid. For example, if a service costs \$50 to provide and Hawaii's Medicaid rate is set at \$25, then the federal revenue for the State is \$13.50--54 percent of the Medicaid expenditure but only 27 percent of the actual cost. State funds then typically are used to pay 100 percent of the unreimbursed \$25 as well as 46 percent of the \$25 Medicaid payment, making its overall cost \$36.50--73 percent of the cost of furnishing the service to a Medicaid recipient.

In addition to setting a policy of full reimbursement for DOH services, Hawaii's Medicaid program would need to establish appropriate billing codes for different types of interventions. A clinic, for example, might furnish comprehensive evaluations, individual therapy sessions, and half-day treatment programs--each of which carries a different cost and requires fair compensation.

Importantly, reimbursement amounts do not have to represent the same proportion of costs for all providers of a given service.⁸ States are permitted to establish separate classes of providers and pay them differentially. Publicly operated health care facilities and state-employed individual practitioners could be a class of providers paid by Medicaid at their full costs, provided that costs do not violate Medicaid's upper limit provisions. Facilities and practitioners that receive state funds (other than Medicaid) could be another. At the same time, other private agencies and practitioners could be a class of providers reimbursed a percentage of their usual and customary rate (UCR).

Billing practices. Critical to a strategy for maximizing federal Medicaid revenue in Hawaii is a mandatory policy that all DOH-funded providers bill regularly for all Medicaid-reimbursable

services. It would be permissible, however, under a formal interagency agreement, to have the Department of Health serve as a billing agent on behalf of some or all of its grantees and contractees.⁹

Although there is a federal prohibition on Medicaid providers receiving reimbursement for services they otherwise make available free, a number of exceptions relevant to Hawaii have been granted. These include the following.¹⁰

- . When Medicaid-covered services offered by or through a Title V Maternal and Child Health agency are billed to Medicaid, the issue of routine charges has been determined not to apply. This is because Medicaid-covered Maternal and Child Health Block Grant services are required by federal Medicaid statute to be reimbursed. (An interagency agreement should be in effect to implement this provision, however.)
- . When a state uses its own funds to pay for services furnished to specific non-Medicaid populations (such as uninsured pregnant women), Medicaid payments may be made to cover the cost of these same services furnished to Medicaid-eligible recipients. In other words, providers may bill Medicaid for covered services even if they receive grant or contract funds to provide services free to other populations.
- . When a Medicaid provider has in place a billing system for recipients with third-party coverage but does not charge the uninsured, Medicaid reimbursement is available. Operationally, this means that Medicaid may pay for services furnished by providers who obtain patient insurance information at the time of intake or the development of a care plan, ascertain from the family and patient whether private insurance claims may be submitted, and then bill insurers as agreed. (Of course, case management, home visiting, and many other DOH-funded services simply are not included in private plans.)

Key Medicaid benefits for DOH-funded programs. Federal Medicaid law establishes both mandatory and optional benefit categories (shown in Appendix B). Certain of these benefits are particularly important in providing appropriate reimbursement for the health and mental health services funded by Hawaii's Department of Health. Among these benefits are: family planning services, clinic services, rehabilitative services, ancillary therapists' services, medical or other remedial care provided by licensed practitioners, and targeted case management.

Family planning services. Family planning services are a mandatory benefit category. Since there are no federal regulations defining these services, states have full latitude in setting policy regarding the nature and scope of these services and the providers able to furnish them. The family planning services benefit category is unique in that it is the only one for which the federal government provides matching funds at a 90 - 10 rate.

Clinic services. Clinic services are an optional benefit category federally defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients. The services must be provided by a facility that is not a hospital but is organized and operated to

provide medical care to outpatients and must be furnished by or under the direction of a physician or dentist.¹¹ HCFA has indicated that clinic services may be provided in a satellite facility or even in a mobile van, but not in a home, classroom, or other location that is separate from a clinic site.

Rehabilitative services. Rehabilitative services may be offered as part of the optional category of diagnostic, screening, preventive, and rehabilitative services. They are defined in the federal regulations to include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts (within the scope of his practice under state law) for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.¹² The rehabilitative services benefit is considered to be an extremely important Medicaid option for the financing of non-traditional health and mental health interventions since these services do not have to be physician prescribed or directed, may be offered by well-trained but not necessarily licensed practitioners, and can be delivered at any location.

Ancillary therapists' services. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are also an optional benefit category. According to federal regulations, the services must be prescribed by a physician but may be furnished in any setting and may include any necessary supplies and equipment. Specific provider qualifications for each service are:

- . Physical therapy is defined as services provided to a recipient by or under the direction of a qualified physical therapist, who must be a graduate of an approved program of physical therapy¹³ and where applicable, licensed by the state.
- . Occupational therapy means services provided to a recipient by or under the direction of a qualified occupational therapist, who must be either registered by the American Occupational Therapy Association, or else a graduate of an approved program in occupational therapy¹⁴ and engaged in the supplemental clinical experience required for registration.
- . Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, who must have a certificate of clinical competence from the American Speech and Hearing Association or else either have completed the equivalent educational requirements and work experience necessary for the certificate or have completed the academic program and be in the process of acquiring supervised work experience to qualify for the certificate.¹⁵

Medical or other remedial care provided by licensed practitioners. This optional category of practitioners' services refers to any medical or remedial care or other services, other than physicians' services, that are provided by licensed practitioners within the scope of practice defined under state law.¹⁶ Physician recommendations are not required and the services may be delivered at any site. This benefit category enables states to provide Medicaid reimbursement

for services furnished by licensed practitioners--such as nurses, psychologists, and clinical social workers--who may be practicing independently as well as in organized settings.

Targeted case management. Case management services are defined as services that will assist eligible individuals in gaining access to needed medical, social, educational, and other services. Unlike other Medicaid services, case management services do not have to be available statewide to all categorically eligible Medicaid recipients: they may be targeted at specific high-risk population groups or geographical areas. In addition, states electing to provide case management to developmentally disabled or mentally ill individuals may specify provider agencies rather than allow all providers who meet provider qualification standards to bill, as is usually required. As yet, there are no federal regulations on case management services, but federal guidelines (in state Medicaid manual transmittals) have been disseminated to the states.

Data limitations. We arrived at estimates of the amount of federal revenue that the 14 selected services might generate by using data provided by DOH staff. To arrive at the amount of potentially available federal Medicaid revenue for each benefit or billing option, we multiplied the total service units that were furnished to DOH clients by the proportion of Medicaid enrollees receiving the service, and then multiplied the resulting number by the unit cost of the service. This yielded a dollar amount that could be reimbursed by Medicaid. To determine what the federal share of the reimbursement would be, we applied Hawaii's 54 percent federal financial participation rate to the dollar amount (except for the use of 90 percent for family planning services). Any currently available federal Medicaid funds were subtracted from the federal share figure to estimate the amount of new federal dollars that could be obtained with improved benefit and billing policies.

Some data limitations should be noted:

- . First, for some services, the divisions were not able to provide us with data on the proportion of recipients who were Medicaid-enrolled. Where this was the case, they estimated the proportion who were Medicaid-eligible and we applied the Medicaid-enrollment rate for Hawaii, as developed from Current Population Survey (CPS) data, to that proportion. Among Medicaid-eligible Hawaii residents generally, the enrollment rate is 53 percent. For certain component groups, however, notably pregnant women and children under age 6, the rate is higher--75 and 60 percent, respectively.
- . Second, few DOH divisions collect ongoing claims information on actual service use by Medicaid enrollees. For this reason, we had to rely on rough estimates of the number of Medicaid enrollees served and apply these to the programs' general utilization data, which consisted almost entirely of overall visit counts as opposed to client-specific utilization.
- . Third, we did not have extensive information on the actual cost of each type of DOH service. For some services, therefore, we had to rely on a very rough estimate of the service

cost for Medicaid enrollees which we developed by multiplying total service expenditures by the proportion of clients who were Medicaid enrolled.

The estimates of potentially available federal revenue we provide are based on the number of Medicaid-*enrolled* clients. If aggressive outreach efforts were made, and all those eligible for Medicaid actually enrolled, the federal revenue figures would be nearly twice as high for most programs.

Federal Medicaid revenue opportunities for Hawaii. Our study of DOH programs and services revealed several limitations in current coverage policy. One critical benefit was not offered; other benefits were defined too narrowly to meet the needs of certain DOH target populations; and another benefit carried a reimbursement rate that often appeared not to cover actual DOH costs for the service. In addition, we found that DOH providers often did not bill the Medicaid program for currently reimbursable services.

To increase federal Medicaid revenue, we recommend that Hawaii:

- . Adopt Medicaid's targeted case management benefit to cover care coordination services furnished to a number of medically complex, developmentally disabled, mentally ill, and other high-risk populations served by Department of Health programs;
- . Permit Medicaid coverage of occupational therapy and physical therapy services delivered to special education students under Hawaii's existing Medicaid ancillary therapy benefit;
- . Expand its Medicaid definition of rehabilitation services to permit coverage of mental health services to students with emotional problems and to adults with severe emotional disability;
- . Adopt Medicaid coverage of certain public health nursing services under the independent licensed practitioner benefit;
- . Increase its Medicaid reimbursement rate for clinic services to reflect the actual service costs of DOH-funded providers; and
- . Require DOH providers of services to bill Medicaid for all Medicaid-reimbursable services.

In this section, we present background information and recommended actions for 14 services operated under eight DOH branches or divisions. For each of the services, we address the following:

- . the nature and purpose of the service;
- . the current amount of state general revenues and state Medicaid revenues available for the service;

- . the size and Medicaid status of the service population;
- . the current Medicaid coverage policies pertaining to the service;
- . the current DOH billing practices, where appropriate;
- . the opportunities that exist to improve federal Medicaid revenue through new or revised benefit policies, increased reimbursement rates, and improved DOH billing practices; and
- . the estimated amount of federal Medicaid revenue that could be obtained if each of these opportunities were pursued.

The estimates of federal Medicaid revenue that we provide are meant to capture only the savings potentially available to the State through appropriately designed Medicaid coverage and reimbursement policies for DOH services. Absent the possibility of DOH establishing certification for its providers and Medicaid then restricting providers of a given service to those with DOH certification, there always will be some risk that private sector providers not affiliated with DOH may be interested in furnishing services similar to those offered through the DOH network. Calculating the potential costs to the Medicaid program associated with possible private sector billing was beyond the scope of this report.

- . For half of our recommendations, however, the issue of private sector interest would *not* even be relevant. This would be the case for adding several categories of a new targeted case management benefit and increasing reimbursement for Title V clinics because federal law allows the benefit and the increased reimbursement, respectively, to be limited to services provided by state-operated programs. It also would be the case for center-based acute mental health services and family planning clinic services because the recommended changes have no effect on providers unaffiliated with DOH.
- . For all but one of our other recommendations, private sector interest could be an issue, but only a *minor* one, either because private providers would have great difficulty meeting Medicaid provider standards or because the reimbursement rate they would receive is comparatively low. This would be the case for adding two categories of the new targeted case management benefit, establishing reimbursement for the Home Visitor program, establishing an early intervention clinic category, revising the occupational therapy and physical therapy benefit to allow reimbursement for therapy provided by therapy assistants in the schools, and revising the rehabilitative services benefit to provide reimbursement for school-based services and services for the severely disabled mentally ill.
- . For the remaining recommendation--concerning patient education and training by nurses under the "other licensed practitioner" benefit--we anticipate that private sector interest could be more of a problem and might result in unintended costs for Medicaid.

It may be, however, that DHS, because of its greater familiarity with private provider markets in Hawaii, will be able to undertake additional analyses and then further refine the service

definitions that we have recommended here in such a way as to minimize or even eliminate participation by non-DOH providers. This would have to be done in tandem with DOH to ensure that the definitions adopted posed no barriers to reimbursement of current DOH providers, or those expected to be used in the future.

1. MATERNAL AND CHILD HEALTH CLINIC SERVICES

The Maternal and Child Health Branch/
The Children With Special Health Needs Branch

Service Description

Hawaii's Title V program¹ -- administered through the Maternal and Child Health Branch (MCHB) and the Children with Special Health Needs Branch (CSHNB) -- includes a number of DOH clinics that provide direct services to children and pregnant women. MCHB operates three clinics: two provide perinatal care to pregnant women; one provides pediatric care to children and youth up to age 16. All furnish basic preventive and primary health care services such as physical examinations, immunizations, laboratory tests, physician services, nursing services and prescriptions, as well as social work and nutrition services. All are staffed by physicians, nurses, and allied health professionals. Most of the physicians are paid under a contractual arrangement. The other staff are all DOH employees.

CSHNB operates on a periodic basis various specialty clinics, such as a cardiac clinic or an orthopedic clinic, to meet the service needs of children with certain types of chronic conditions. Although the clinics offer multi-disciplinary services that include nutrition, ancillary therapy, and other services, the bulk of care furnished at the clinics is delivered by private specialty physicians under contract to CSHNB and nurses employed by the Public Health Nursing Branch of DOH. All services essentially are provided at the clinic sites.

State Funding

In fiscal year 1988-89, state general funds expended on Title V clinics totaled an estimated \$458,980: \$277,450 for the Children and Youth (C & Y) clinic; \$148,120 for the Maternity and Infant Care (MIC) clinics; and \$33,410 for the special need clinics. This represented 79 percent of the Title V clinics' total funding.²

Total Medicaid reimbursement to the clinics in that year amounted to \$28,450, of which about \$13,090 were state funds. The funds were retained by the Branches in trust funds under an exception to the basic

¹ A state's maternal and child health program and program for children with special health needs generally are referred to collectively as its "Title V program." Title V refers to Title V of the Social Security Act, under which federal funds are made available to these state programs at a matching ratio of \$4 federal to \$3 state.

² The remaining 21 percent were federal Title V funds.

1. MATERNAL AND CHILD HEALTH CLINIC SERVICES

The Maternal and Child Health Branch/ The Children With Special Health Needs Branch (continued)

rule that would require Medicaid reimbursements to be deposited to the general fund.³

Service Population

MCHB clinics serve only individuals who reside in the census tracts in which the clinics are located and -- for some services -- only those whose family income is less than a certain percentage of poverty.⁴ In fiscal year 1987-88, the three clinics served a total of 2,100 clients, or an estimated 45 percent of their target populations. Intake statistics on the insurance status of persons served indicate that, on average, 24 percent of clients are Medicaid-enrolled.⁵

CSHNB makes its clinic services available to children up to age 21 who have any one of a number of specified chronic diseases or disabilities and whose family income is less than 175 percent of poverty. Statistics compiled by CSHNB do not provide an accurate count of children receiving clinic services, but the actual number may be as many as 1,000. Branch statistics indicate that 14 percent of the children they serve are in the Medicaid program.⁶

³ H.R.S. secs. 37-31, 37-40, 37-54 (1985).

⁴ Comprehensive prenatal care and delivery services at MIC clinics are available only to women whose family income is less than 175 percent of poverty. Acute care services at the C & Y clinic are available only to children whose family income is less than 140 percent of poverty.

⁵ Effective April 1, 1990, the proportion will be substantially higher since federal law then will require states to provide Medicaid eligibility to all children up to age six whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted on November 21, 1989).

⁶ Ibid.

1. MATERNAL AND CHILD HEALTH CLINIC SERVICES

The Maternal and Child Health Branch/
The Children With Special Health Needs Branch
(continued)

Current Hawaii Medicaid Coverage Policies

Medicaid reimbursement for all or nearly all Title V clinic services already is available under two Medicaid categories: physician services and clinic services. With the exception of EPSDT screens, clinics bill at the physician rate for physician services and the clinic rate for other services. The reimbursement rate for clinic services is set at \$14 per visit, with separate reimbursement rates for drugs and laboratory services. There is no limit on the number of clinic visits that can be reimbursed.

The \$14 per visit reimbursement does not adequately reimburse Title V clinics for the actual cost of serving Medicaid clients. The actual average cost at the Title V clinics currently ranges from \$37 to \$140.⁷

Current DOH Practices with Respect to Medicaid

Title V clinics are billing Medicaid for some, but not all, reimbursable services. For example, at one clinic approximately 420 clients were Medicaid-enrolled in fiscal year 1988-89 and they made an estimated 1,530 visits during the year. Even at the \$14 clinic visit reimbursement rate, Medicaid reimbursement for the outpatient visits alone should have been \$21,420. Yet, total Medicaid reimbursement for that year -- including amounts reimbursed for inpatient care -- was only \$22,678.

Improved Medicaid Coverage Opportunities

Increased Reimbursement: Additional federal funds would be available if Medicaid reimbursement rates for Title V clinics were increased to cover the actual cost of furnishing services to Medicaid recipients. This can be done by establishing a separate reimbursement rate for state-operated facilities that would be based on actual costs.

Mandated Billing: Title V clinics could be mandated to bill Medicaid for all covered services provided to Medicaid recipients.

⁷ The \$140 figure represents the cost of a comprehensive, multi-disciplinary prenatal visit made to the Maternal and Infant Care Projects.

1. MATERNAL AND CHILD HEALTH CLINIC SERVICES

The Maternal and Child Health Branch/
The Children With Special Health Needs Branch
(continued)

Estimated New Federal Revenues

Assuming that 24 percent of the recipients of MCHB clinic services and 14 percent of the recipients of CSHNB clinic services are Medicaid-enrolled, maximized billing for these clients -- even at the basic \$14 clinic rate -- should result in total Medicaid reimbursements of about \$30,700, of which the federal share would be about \$16,600. Last fiscal year, only \$14,600 in federal Medicaid funds were obtained by Title V clinics, and this included billings for physician services at a significantly higher rate.

If reimbursement rates for Title V clinics were raised to the level of actual service costs -- estimated to be \$40 for both C & Y and CSHNB clinics and \$140 for MIC clinics, assuming clinic efficiency -- Medicaid reimbursement could be as much as \$131,400. The new federal share would amount to about \$70,960, an increase of at least \$47,360 over the amount of federal funds previously obtained.

There would be no potential for unintended Medicaid costs because increasing Title V Medicaid reimbursement would have no effect on other providers.

2. THE HOME VISITOR PROGRAM SERVICES

The Maternal and Child Health Branch

Service Definition

The Home Visitor Program furnishes a variety of maternal and child health family support services aimed at preventing child abuse and neglect. The program provides for the screening and identification of newborns at high-risk for child abuse and neglect. Families found to be at-risk receive regular home visits for up to one year. The service is aimed at fostering parent/child bonding and interaction; assisting in the use of community resources such as alcohol and drug abuse treatment programs, infant stimulation programs, and spouse abuse shelters; and helping to access welfare, Medicaid, and other benefits for which families may be eligible. The screens and home visits are provided by professional and paraprofessional staff employed by eight private agencies under contract to the Maternal and Child Health Branch.

State Funding

The program is funded entirely with state general funds. The state appropriation for fiscal year 1989-90 is \$3.5 million.

Service Population

It is expected that in fiscal year 1989-90 approximately 9,800 new mothers, accounting for 53 percent of the annual births in Hawaii, will be screened. Based on these screenings, approximately 1,470 families will receive home visiting interventions. Most of these families -- about 70 percent at the time of screening and 60 percent through the remainder of the year -- are estimated to be Medicaid-eligible. It is not known how many actually are enrolled, but the Medicaid enrollment rate among pregnant women in Hawaii, on average, is 75 percent of those eligible.

Current Hawaii Medicaid Coverage Policies

Home visitor services currently are not covered by the Hawaii Medicaid program.

Medicaid Coverage Opportunities

Revised Benefit: Medicaid reimbursement for the screening component of the home visitor program could be obtained by revising the EPSDT screening protocol to provide for an in-hospital high-risk newborn

2. THE HOME VISITOR PROGRAM SERVICES

The Maternal and Child Health Branch (continued)

screen with a separate billing code.⁸ Providers could be limited to public and private community agencies approved by DOH as meeting comprehensive Medicaid provider standards that address organizational capability; MCHB coordination and referral agreements; supervisory capacity; and the education, work experience, and training of screening staff.

Hawaii could establish separate reimbursement rates for the newborn screen for two classes of providers: one would be agencies receiving state funds and would provide reimbursement at full costs, or DOH costs if they were less, and the other would be private providers unaffiliated with DOH and would provide reimbursement at the percentage of UCR that Medicaid currently pays.

New Benefit: Reimbursement for most of the home visitor service could be obtained by establishing a targeted case management benefit for new mothers who, at the time of delivery, are assessed by the Maternal and Child Health Branch (MCHB) or its' contractees as being at high risk for child abuse or neglect and requiring assistance in accessing appropriate services.⁹ Providers could be limited to public and private community agencies approved by DOH as meeting comprehensive Medicaid provider standards that address organizational capability; MCHB coordination and referral agreements; supervisory capacity; and the education, work experience, and training of case management staff.¹⁰

Hawaii could establish separate sets of reimbursement rates for home visitor services for two classes of providers: one would be private agencies receiving state funds and would provide reimbursement at full

⁸ This would have the added benefit of enrolling all Medicaid-eligible newborns in the EPSDT program.

⁹ At least 18 states have provided for a newborn EPSDT screen and at least one state (Washington) has a targeted case management benefit that includes home visits to environmentally at-risk children. Overall, we are aware of 26 states that have amended their state plans to include reimbursement of case management services under the targeted case management benefit. Eleven of these states use multiple targeted case management subcategories to best meet the needs of diverse targeted groups.

¹⁰ It might be appropriate for Hawaii to consider establishing state certification for Home Visitor Program case managers in order to ensure quality of care.

2. THE HOME VISITOR PROGRAM SERVICES

The Maternal and Child Health Branch (continued)

costs, or DOH costs if they are less, and the other would be private agencies unaffiliated with DOH and would provide reimbursement at the percentage of UCR that Medicaid currently pays. Billing codes would account for home and other off-site visits, as well as telephone and office contacts.¹¹

Mandated Billing: All screening and home visit providers could be required to bill the Medicaid program for covered services.

Estimated New Federal Revenues

By adding the newborn high-risk screen to the EPSDT screening protocol and establishing a targeted case management benefit for the high-risk mothers, Medicaid reimbursement could total as much as \$1.67 million in fiscal year 1989-90, of which the federal share would be about \$900,000. This estimate was developed as follows.

Assuming a Medicaid-enrollment rate of 53 percent at the time of screening (75 percent of the 70 percent eligible), approximately 5,200 screens at an actual cost of \$120 could be billed to Medicaid in fiscal year 1989-90. Thus, only adding the newborn high-risk screen to the EPSDT screening protocol would result in a total of \$336,960 in new federal Medicaid matching funds.

Assuming a Medicaid-enrollment rate of 45 percent during the home visit period (75 percent of the 60 percent with continuing eligibility), and that 90 percent of the services could be reimbursed, Medicaid payment would be available for approximately 660 women who could be served at an actual cost averaging \$1,755 per case. Thus, establishing a targeted case management benefit would result in \$563,000 in new federal funds.

There could be some small potential for unintended Medicaid costs associated with establishing coverage for the home visitor program because the availability of this new Medicaid benefit could encourage additional private providers to attempt to qualify for screening and targeted case management reimbursement. However, such providers may be deterred by the low reimbursement rate available to them and effectively precluded from qualifying by the requirement to have coordination and referral agreements.

¹¹ A number of states reimburse case management services based on 15-minute intervals of time. Others use monthly capitation rates, but the validity of these have been seriously questioned both by the states and HCFA.

3. FAMILY PLANNING SERVICES

The Maternal and Child Health Branch

Service Description

The Maternal and Child Health Branch (MCHB) funds family planning services at 13 clinic sites throughout the state. Three of the family planning clinics are operated by DOH and the other 10 are operated by private contracting agencies. All of the clinics operate under the direction of a staff or consulting physician, but many use nurse practitioners and, to some extent, paramedical assistants, to provide the bulk of service. They provide comprehensive physical examinations; sexually-transmitted disease education, screening, and follow-up; birth control prescription and filling; infertility screening; voluntary sterilization counseling; and pregnancy options counseling.

State Funding

State funds expended on family planning clinics in fiscal year 1988-89 totaled about \$744,090, 48 percent of the clinics' total funding.¹²

The amount of Medicaid reimbursement received by the family planning clinics could not be obtained. Based on the number of visits made by Medicaid enrolled women, we estimate it to have been approximately \$15,680, of which about \$7,200 would have been state funds. The clinics retain these Medicaid funds in a trust fund under an exception to the general rule requiring Medicaid reimbursements to be deposited in the state general fund.¹³

Service Population

Family planning clinics provide services to low-income women and women at risk for unintended pregnancy. In fiscal year 1988-89, the family planning clinics served 15,944 clients -- about 17 percent of the number the Alan Guttmacher Institute estimated as Hawaii's family planning target population. MCHB data indicate that 19 percent of family planning clients, about 3,035 women, are Medicaid enrolled.

Current Hawaii Medicaid Coverage Policies

Family planning clinic visits are eligible for reimbursement under the Medicaid program's existing clinic services benefit. For all but one clinic, the Hawaii Medicaid payment rate is \$14 per visit, with

¹² The remaining 52 percent were federal funds.

¹³ H.R.S. sec. 37-31, 37-40, 37-54 (1985).

3. FAMILY PLANNING SERVICES

The Maternal and Child Health Branch (continued)

additional payment made for drugs and laboratory services. The sole exception is Hawaii Planned Parenthood, which has an all-inclusive rate of \$43. There is no limit on the number of family planning clinic visits that can be reimbursed.

As is the case with Title V clinics, Medicaid reimbursement rates for family planning clinics appear to fall short of actual service costs. Program statistics indicate that while the basic Medicaid reimbursement rate for most clinics is \$14, the actual per visit service cost is, on average, about \$68. Although there is an obvious question of efficiency in the operation of these clinics, it is clear that state-only funds are to some extent subsidizing the care of Medicaid-enrolled women because the Medicaid rates themselves are too low to cover costs.

Current DOH Practices with Respect to Medicaid

Family planning clinics are missing opportunities to obtain Medicaid revenue. Assuming 19 percent of the clients are Medicaid enrolled, and further assuming an average of 1.7 visits per client per year, Medicaid could have been billed for as many as 5,160 visits last year. Yet, program statistics suggest that only about 1,120 visits would have been billed to Medicaid.

Increased Reimbursement: Additional federal revenue could be obtained by raising reimbursement rates to reflect the actual cost of the services provided. Separate sets of reimbursement rates could be established for three classes of providers: one would be state-operated clinics and would provide reimbursement at full costs; a second would be clinics receiving state funds and would provide reimbursement at full

¹⁴ At least 10 states currently reimburse family planning clinic services under the federally defined family planning services benefit.

3. FAMILY PLANNING SERVICES

The Maternal and Child Health Branch (continued)

costs, or DOH costs if they are less; a third would be clinics unaffiliated with DOH and would provide reimbursement at the regular clinic rate (\$14 per visit) already available. Billing codes would include initial/annual visit, routine revisit, problem revisit, laboratory tests, and both prescription and non-prescription birth control devices.

Mandated Billing: All DOH-funded planning providers could be required to bill Medicaid for all covered services provided to Medicaid recipients. Achieving maximum billing by family planning providers, however, perhaps also would require policy changes regarding:

- confidentiality protections for adolescents, and
- quick access by providers to current Medicaid enrollment information from HMSA.

Estimated New Federal Revenues

(These estimates are based on all DOH-funded services -- those provided at public sites directly operated by DOH and those provided at private sites operating under contract to DOH.)

Assuming that 19 percent of family planning clinic clients are enrolled and that they make an average of 1.7 visits per year, maximum Medicaid billing by family planning clinics under the existing clinic category, at the current \$14 reimbursement rate and at the special 90 percent FFP, could result in at least \$72,240 in Medicaid reimbursement, yielding \$65,000 in federal funds -- an increase of about \$50,900 over federal Medicaid revenue obtained last year.

3. FAMILY PLANNING SERVICES

The Maternal and Child Health Branch (continued)

Assuming that an increase in the reimbursement rate for DOH-funded clinics to \$40 would cover the actual average cost of an efficiently delivered family planning visit, as much as \$206,000 in Medicaid reimbursement could be obtained by taking these steps, of which about \$185,400 would be federal dollars. This would be an increase of about \$171,300 over federal Medicaid revenue estimated to have been obtained last year.

There would be no potential for unintended Medicaid costs because these changes have no effect on the number of providers that could obtain reimbursement for family planning services or on the amount of reimbursement available to clinics not affiliated with DOH.

4. CASE MANAGEMENT FOR EARLY INTERVENTION RECIPIENTS

The Children With Special Health Needs Branch

Service Description

The case management service, which the Hawaii Zero-to-Three Project (the DOH program that oversees early intervention activities in the state) expects to be implemented soon, will consist of care planning, arranging for appropriate services, monitoring service delivery, and general client advocacy. The services will be provided to the early intervention population: infants and toddlers who have manifested developmental delay or are at high-risk for such delay due to biological or environmental factors. They will be delivered by 14 social workers employed by the Research Corporation of the University of Hawaii, at Infant Development Programs operated by or under contract to the Community Services for the Developmentally Disabled Branch, in children's homes, various other settings, and over the telephone.

State Funding

The 14 case manager positions have been financed exclusively with state funds. The appropriation for fiscal year 1989-90 was approximately \$425,000.

Service Population

Early intervention case management services are expected to be furnished to about 850 infants and toddlers and their families. The great majority will be children with manifest developmental delay who are receiving services from Infant Development Programs. Staff estimate that approximately 35 percent of case management recipients will be Medicaid eligible.¹⁵ Because about 60 percent of children under age 6 in Hawaii who are eligible for Medicaid actually are enrolled, we estimate that about 21 percent of these infants and toddlers will be covered by Medicaid.

Current Hawaii Medicaid Coverage Policies

Case management services for the early intervention population currently are not covered under Hawaii's Medicaid program.

¹⁵ Effective April 1, 1990, the proportion will be substantially higher since federal law will then require states to provide Medicaid eligibility to all children up to age 6 whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted on November 21, 1989).

4. CASE MANAGEMENT FOR EARLY INTERVENTION RECIPIENTS

The Children With Special Health Needs Branch (continued)

Medicaid Coverage Opportunities

New Benefit: Reimbursement for case management services for the early intervention population could be obtained by adding a targeted case management benefit to the state Medicaid plan. The benefit could be structured for children ages birth to three who have manifest developmental delay, or are at risk for developmental delay due to biological or environmental factors.¹⁶ Federal law permits states to designate specific providers of case management services to the early intervention population so that the provider agencies could be limited to the Infant Development Programs, with the Hawaii Zero-to-Three Program perhaps serving as the billing agent.

Reimbursement for early intervention case management services would be at full costs. Billing codes would account for home and other off-site visits as well as telephone and office contacts.¹⁷

Mandated Billing: All DOH early intervention case management providers could be required to bill Medicaid for covered services.

Estimated New Federal Revenues

Assuming that 21 percent of the children served are Medicaid enrolled, total Medicaid reimbursement for case management could be as much as \$89,250, with the federal share amounting to about \$48,200.

There would be no potential for unintended Medicaid costs associated with the establishment of an early intervention case management benefit because providers would be limited to DOH staff.

¹⁶ One state (Washington) currently has a targeted case management benefit that includes the early intervention population. Several other states have indicated to us their intent to submit targeted case management amendments for this population. At least 26 states have amended their state plans to provide reimbursement of case management services under the targeted case management benefit. Eleven of these states use multiple targeted case management subcategories to best meet the needs of diverse targeted groups.

¹⁷ A number of states reimburse case management services based on 15-minute intervals of time. Others use monthly capitation rates, but the validity of these have been seriously questioned both by the states and HCFA.

5. CENTER-BASED SERVICES FOR DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS

Community Services for the Developmentally Disabled Branch

Service Description

Infant Development Programs administered by the Community Services for the Developmentally Disabled Branch (CSDDDB) provide early intervention services to developmentally delayed children from birth to three years of age. Early intervention may include physical therapy, occupational therapy, speech/language pathology and audiology, psychology, social work, nutrition, and special education services, and is provided by a mix of professionals and paraprofessionals. Parent training and counseling also is provided to support a child's therapy. The services are almost exclusively center-based and are offered by 12 Infant Development Programs, 5 operated directly by CSDDDB, and 7 operated under contract by private non-profit agencies.

State Funding

The Infant Development Programs are entirely state funded. State expenditures for fiscal year 1988-89 were just over \$1.4 million.

Service Population

In fiscal year 1988-89, the Infant Development Programs (IDPs) served 637 children, or about 50 percent of the 1,200 infants and toddlers estimated by state staff to be eligible. Data on Medicaid enrollment among these children is not available, but staff estimate that about 35 percent would be eligible for coverage.¹⁸ Since, on average, 60 percent of children under age 6 in Hawaii who are eligible for Medicaid actually are enrolled, we estimate that about 21 percent of Infant Development Program clients will be covered by Medicaid.

Current Hawaii Medicaid Coverage Policies

Under Hawaii's current Medicaid program, early intervention services provided by certain licensed practitioners -- clinical psychologists, physical therapists, occupational therapists, or speech therapists -- could be reimbursed as independent practitioner services and no specific visit limit would apply. Reimbursement of these services is made at 56 percent of the provider's 1987 UCR. In addition, the IDPs

¹⁸ Effective April 1, 1990, the proportion will be substantially higher since federal law will then require states to provide Medicaid eligibility to all children up to age 6 whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted by Congress on November 21, 1989).

5. CENTER-BASED SERVICES FOR DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS

Community Services for the Developmentally Disabled Branch (continued)

themselves could be reimbursed as clinic services providers and obtain reimbursement at \$14 per visit for an unlimited number of visits, with prior authorization.

Current DOH Practices with Respect to Medicaid

Infant Development Programs have not attempted to bill Medicaid for covered services. The IDPs were unaware that Medicaid reimbursement under the clinic services benefit was available to them and so never sought Medicaid provider certification. None of the licensed professionals employed by the IDPs billed Medicaid for services as individual practitioners and it is unknown what proportion of these actually are Medicaid certified.

Improved Medicaid Coverage Opportunities

Revised Benefit: The optimal mechanism for reimbursing early intervention services provided by Infant Development Programs is under the state's existing Medicaid clinic services benefit. This benefit could be delineated further to identify a new clinic sub-category, termed "early intervention clinics."¹⁹

This approach would permit reimbursement for services provided by both licensed and unlicensed practitioners and would permit reimbursement rates to be tailored to reflect the actual cost of providing early intervention services. Provider clinics could be limited to public or private entities that meet Medicaid provider standards relating to organizational capability; supervisory capacity; coordination and referral agreements with CSDDB and the Hawaii Zero-to-Three Project; and the education, work experience, and training of staff.

To maximize federal revenue for Hawaii, separate sets of reimbursement rates could be established for three classes of providers: one would be state-operated clinics and would provide reimbursement at full

¹⁹ Massachusetts already has established a distinct "early intervention clinic" category, and several other states have indicated to us their intent to develop an early intervention clinic category. Of the 47 states that provide reimbursement under the clinic services benefit, 37 define the benefit in terms of specific types of clinics, each with its own client eligibility criteria, allowable services and providers, and service limits. For example, separate clinic categories might be defined for Community Health Centers, mental health clinics, substance abuse treatment clinics, Title V clinics, and ambulatory surgical centers.

5. CENTER-BASED SERVICES FOR DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS

Community Services for the Developmentally Disabled Branch (continued)

costs; a second would be clinics receiving state funds and would provide reimbursement at DOH costs;²⁰ a third would be clinics unaffiliated with DOH and would provide reimbursement at the regular clinic rate (\$14 visit) already available to them. The billing codes that would be needed are: individual and family therapy, child-focused group therapy, parent-focused group therapy, screening and assessment, and therapeutic nursery (three hours).

Mandated Billing: Infant Development Programs could be required to bill Medicaid for covered services provided to Medicaid recipients.

Estimated New Federal Revenues

(This estimate is based on all DOH-funded services -- those provided at public sites directly operated by DOH and those provided at private sites operating under contract to DOH.)

Assuming that approximately 20 percent of the clients are Medicaid-enrolled, and that all center-based early intervention services would be Medicaid-reimbursable, new Medicaid reimbursement would total \$280,000 of which the federal share would be about \$151,200.

Federal revenue for early intervention services could be even greater if reimbursement rates were set to reflect reasonable service costs, although the state share of the Medicaid reimbursement amount would increase commensurately.

There could be some small potential for unintended Medicaid costs associated with the delineation of an early intervention clinic category, because the availability of this new Medicaid category could encourage additional providers to attempt to qualify for Medicaid early intervention clinic reimbursement. However, these providers may be deterred because of low reimbursement rates and effectively precluded from qualifying by the requirement that there be coordination and referral agreements.

²⁰ It is our understanding that DOH payments to the private providers have been kept artificially low. The director of Hawaii's Zero to Three Project reports that, as a result, private agencies suffer from frequent turnover, low morale, and high burnout. The 1990 Report, being prepared by the State Planning Council on Developmental Disabilities makes as one of its prime recommendations that private agency salaries at least be brought up to par with state salaries.

6. CASE MANAGEMENT FOR DEVELOPMENTALLY DISABLED ADULTS

Community Services for the Developmentally Disabled Branch

Service Description

Case management services entail the assignment of a case manager who assesses the clients needs, and provides, arranges for, and monitors the delivery of appropriate services. Case management services currently are provided to clients of the Placement and Continuing Support Services (PCSS) unit of the Community Services for the Developmentally Disabilities Branch (CSDDDB). The services are provided by state-employed professionals and paraprofessionals, and generally are delivered via the telephone, in the office, or in the client's home.

State Funding

These case management services are funded entirely with state dollars. State expenditures for case management services in fiscal year 1988-89 were about \$1,416,600.

Service Population

CSDDDB is providing case management to 1,046 adults in fiscal year 1989-90, about 50 percent of its estimated target population. Data from CSDDDB indicate that about 70 percent of these clients are eligible for Medicaid. Because approximately 53 percent of all Hawaii residents eligible for Medicaid actually enroll, we estimate that about 42 percent of the case management clients would be Medicaid enrolled.

Current Hawaii Medicaid Coverage Policies

Case management services for the developmentally disabled currently are not covered under Hawaii's Medicaid program.

Improved Medicaid Coverage Opportunities

New Benefit: Reimbursement of case management services for adult clients of CSDDDB could be obtained by adding a targeted case management benefit to the state Medicaid plan. The benefit could be structured for developmentally disabled adults residing in the community who have been

²¹ At least 6 states already have amended their state plans to provide reimbursement of case management services to the developmentally disabled under the targeted case management benefit. Overall, at least 26 states have amended their state plans to provide reimbursement of case management services under the targeted case management benefit. Eleven of these states use multiple targeted case management subcategories to best meet the needs of diverse targeted groups.

6. CASE MANAGEMENT FOR DEVELOPMENTALLY DISABLED ADULTS

Community Services for the Developmentally Disabled Branch (continued)

assessed by the PCSS unit as requiring case management services to access and coordinate various types of interventions and assistance.²¹ Federal law permits states to designate specific providers of case management services to the developmentally disabled population so that providers could be limited to case managers employed by the PCSS unit.

Reimbursement for developmentally disabled case management services would be at full costs. Billing codes would account for home and other off-site visits, as well as telephone and office contacts.²²

Mandated Billing: All DOH-funded case management providers for the developmentally disabled could be required to bill Medicaid for covered services.

Estimated New Federal Revenues

Assuming that about 42 percent of case management service recipients were Medicaid-enrolled, and that all case management services provided would be reimbursed under a new targeted case management option, total Medicaid reimbursement could be as much as approximately \$595,000. The federal matching share would amount to \$321,300.

There would be no potential for unintended Medicaid costs associated with the establishment of a developmentally disabled case management benefit because providers would be limited to DOH staff.

²² A number of states reimburse case management services based on 15-minute intervals of time. Others use monthly capitation rates, but the validity of these have been seriously questioned both by the states and HCFA.

7. SCHOOL-BASED OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

School Health Services Branch

Service Description

The School Health Services Branch (SHSB) is obligated by state statute, and an implementing interagency agreement, to provide occupational therapy and physical therapy to special education students who require them.²³ The services include evaluations, treatments, and consultations. They are furnished by licensed physical and occupational therapists and by occupational therapy assistants employed directly by the SHSB.²⁴

State Funding

State expenditures for school-based physical and occupational therapy services in fiscal year 1988-89 totaled \$1.62 million, 99 percent of the total funding.²⁵

Service Population

All children enrolled in special education and assessed as needing physical or occupational therapy services receive these services in accordance with their individualized education plans (IEP). In fiscal year 1988-89, some 1100 children received physical therapy services and some 1500 received occupational therapy services. There are no data available within SHSB or the Department of Education on the proportion of special education students who are Medicaid-enrolled. Among children in Hawaii generally, 11 percent are enrolled in the Medicaid program.²⁶ We can assume that for special education students, however, the figure would

²³ This obligation is limited by state law to the extent that state funding is available to cover the cost of service delivery. This limit has been and continues to be the subject of litigation.

²⁴ Due to staff vacancies, the SHSB also occasionally contracts with private agencies or individuals to provide physical therapy and occupational therapy services.

²⁵ The remaining one percent were federal funds.

²⁶ Effective April 1, 1990, the proportion will be somewhat higher since federal law will then require states to provide Medicaid eligibility to all children up to age 6 whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted on November 21, 1989).

7. SCHOOL-BASED OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

School Health Services Branch (continued)

be at least as high as 15 percent since there is a greater incidence of disability among low-income individuals.

Current Hawaii Medicaid Coverage Policies

Hawaii's Medicaid program currently covers services provided by or under the direction of licensed physical and occupational therapists. The plan requires that the recipient be expected to improve within a reasonable amount of time and that prior authorization be given by Medicaid staff, but it places no limits on the amount of therapy that may be reimbursed. The administrative rules specify, however, that only "licensed" practitioners may provide the services. Reimbursement is made at 56 percent of the provider's 1987 UCR.

Current DOH Practices with Respect to Medicaid

Although the existing Medicaid benefit would permit reimbursement for the therapy services furnished by two-thirds of SHSB therapists -- those that are licensed -- it has been assumed that an interagency agreement between the Departments of Health and Education makes this impossible. The agreement states that DOH services will be provided in the schools free of charge.

Improved Medicaid Coverage Opportunities

Revised Benefit: In order to bill Medicaid for all school-based ancillary therapies, a special sub-category for occupational and physical therapy services could be established administratively that does not restrict reimbursement for occupational therapy to that furnished by licensed providers only. Covered services could be those provided pursuant to an individualized education plan (IEP) or other treatment plan developed by a multidisciplinary team, including educators, ancillary therapists, and parents and prior authorized by the School Health Services Branch in order to allow an individual to benefit from primary or secondary education. Provider agencies and individuals could be limited to public or private entities that meet Medicaid provider standards relating to DOE coordination and referral agreements and to the education and work experience of practitioners.

To maximize federal revenue for Hawaii, separate sets of reimbursement rates could be established for three classes of providers: one would be state-employees and would provide reimbursement at full costs; a second would be private agencies or individuals that receive state funds and would provide reimbursement at full costs, or DOH costs if they are less; a third would be private providers or individuals unaffiliated with DOH and would provide reimbursement at the percentage of UCR that

7. SCHOOL-BASED OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

School Health Services Branch (continued)

currently pays. Billing codes could include at least assessment, individual therapy, group therapy, and collateral contacts.

Revised DOH/DOE Agreement: The interagency agreement between the Departments of Health and Education would have to be revised to allow billing to Medicaid. The revised agreement could state that services will be provided in the schools at no cost "to parents" and could indicate that public (and private) health insurance information and billing permission will be obtained from parents on a voluntary basis.

Mandated Billing: All DOH-funded therapy providers could be required to bill Medicaid for covered services.

Estimated New Federal Revenues

(These estimates are based on all DOH-funded services -- those provided by state employees and those provide by private agencies or individuals working under contract to DOH.)

Total state expenditures for physical and occupational therapy were \$1.62 million in fiscal year 1988-89. Assuming that 15 percent of these funds were expended for Medicaid-enrolled children and that all of the services provided to these children could be reimbursed under the independent practitioner option for physical and occupational therapists, we estimate that \$243,000 in state funds were expended on potentially reimbursable services. If reimbursement rates for these services were set at an amount reflecting actual cost, Medicaid reimbursement would total \$243,000, of which the \$131,220 would be new federal revenue.

Should DOE be required to operate its handicapped services program as a true entitlement (as is federally mandated) and increase both the number of students enrolled as special education and the amount of related services they receive, then Medicaid expenditures for occupational therapy and physical therapy would increase. However, without Medicaid coverage these additional expenses would be borne fully by the state.

There could be some small potential for unintended Medicaid costs associated with the establishment of a subcategory allowing for Medicaid reimbursement of occupational therapy assistants because the availability of this new coverage could encourage additional providers to attempt to qualify for reimbursement. However, these providers may be deterred by the relatively low reimbursement rate available to them and effectively precluded from qualifying by the requirements to have DOE coordination and referral agreements and to have a treatment plan developed by a multidisciplinary team including educators.

8. CARE COORDINATION FOR DISABLED OR HIGH-RISK COMMUNITY RESIDENTS

The Public Health Nursing Branch

Service Description

Care planning and coordination are services provided by Public Health Nursing Branch (PHNB) staff primarily to three groups of clients -- disabled children receiving services from the Children with Special Health Needs Branch, the frail elderly, and persons at high-risk for morbidity or mortality. The services are provided by state-salaried nurses who assess each client's needs, provide or arrange for delivery of necessary services, schedule transportation, and arrange for periodic case conferences with the client's family and service providers. Care coordination is done primarily through telephone contacts and home visits.

State Funding

The amount of state general revenue funds expended on care coordination could not be estimated by the PHNB. We know, however, that total state funding for the Public Health Nursing Branch was approximately \$5.4 million in fiscal year 1988-89, 90 percent of its total funding,²⁷ and that care coordination comprises a substantial amount of public health nurses' time.

Service Population

PHNB estimates that about 15,400 individuals received on-going care coordination services in fiscal year 1988-89. This includes 2,050 handicapped children, 550 tuberculosis patients, and 500 frail elderly, as well as over 12,000 persons who, for a variety of reasons, are at high-risk of mortality or morbidity. PHNB data indicate that approximately 20 percent of their clients are Medicaid-enrolled. The proportion would likely be greater for those receiving care coordination since there is a greater incidence of disability and need for community care among low-income individuals.

Current Hawaii Medicaid Coverage Policies

Care coordination by public health nurses is not covered under the Hawaii Medicaid program.

Medicaid Coverage Opportunities

New Benefit: Care coordination services could be covered by adding a targeted case management benefit to the state Medicaid plan. The benefit could be structured for children and adults who have complex medical conditions or disabilities, or are at risk for morbidity or

²⁷ The remaining 10 percent were federal funds.

8. CARE COORDINATION FOR DISABLED OR HIGH-RISK COMMUNITY RESIDENTS

The Public Health Nursing Branch (continued)

mortality, and who are assessed by the PHNB as requiring care coordination assistance to access needed services.²⁸ Providers could be limited to public and private agencies approved by DOH as meeting comprehensive Medicaid provider standards that address organizational capability; coordination and referral agreements with the PHNB, the CSHNB, and the Hawaii State Office on Aging; supervisory capacity; and the education, work experience, and training of case management staff.

Hawaii could establish separate sets of reimbursement rates for care coordination for two classes of providers: one would be state-operated agencies and would provide reimbursement at full costs and the other would be private agencies unaffiliated with DOH and would provide reimbursement at the percentage of UCR that Medicaid currently pays. Billing codes would account for home and other off-site visits, as well as telephone and office contacts.²⁹

Mandated Billing: All DOH-funded care coordination providers could be required to bill Medicaid for all covered services.

Estimated New Federal Revenues

PHNB was not able to make a reliable estimate of the cost of providing care coordination services. For this reason, we could not estimate the amount of federal revenue that might be generated by amending the state Medicaid plan to include care coordination services. Care coordination is one of the major services provided by PHNB, however, so that the state could expect a significant gain in federal funds.

There could be some small potential for unintended Medicaid costs associated with establishing coverage for this targeted case management category because the availability of this new Medicaid benefit could encourage additional private providers to attempt to qualify for reimbursement. However, such providers may be deterred by the low reimbursement rate available to them and effectively precluded from qualifying by the requirement to have coordination and referral agreements.

²⁸ At least 26 states have amended their state plans to provide reimbursement of case management services under the targeted case management benefit. Eleven of these states use multiple targeted case management subcategories to best meet the needs of diverse targeted groups.

²⁹ A number of states reimburse case management services based on 15-minute intervals of time. Others use monthly capitation rates, but the validity of these have been seriously questioned both by the states and HCFA.

9. PATIENT TRAINING AND EDUCATION FOR DISABLED COMMUNITY RESIDENTS

The Public Health Nursing Branch

Service Description

Patient care training and education for the families of disabled children, frail elderly, and high-risk individuals is provided by nurses employed by PHNB. This service may include training in the use of special equipment; instruction in carrying out activities of daily living; teaching caregivers to check vital signs, use physicians appropriately, and administer medications; and monitoring caregiving skills. These services are rendered primarily through visits to the recipient's home.

State Funding

The amount of state general revenue funds expended on patient training and education could not be estimated by the PHNB. Total state funding for the PHNB was approximately \$5.4 million in fiscal year 1988-89, 90 percent of its total funding,³⁰ and patient training and education makes up a substantial part of the nurses' work.

Service Population

PHNB estimates that the caregivers of about 18,700 individuals received training and education in patient care in fiscal year 1989. PHNB data indicate that approximately 20 percent of their clients, in general, are Medicaid-enrolled. The proportion would likely be greater for those receiving patient training and education services since there is a greater incidence of disability among low-income individuals.

Current Hawaii Medicaid Coverage Policies

Patient training and education provided in a patient's home is not covered and services provided independently by nurses are not reimbursable under the Hawaii Medicaid program.

Medicaid Coverage Opportunities

Revised Benefit: Patient training and education services could be reimbursed by Medicaid under the category of "Other Medical and Remedial Care Provided by Licensed Practitioners." The state Medicaid plan could be amended to allow nurses to be reimbursed as independent practitioners for the purpose of providing patient training and education services, pursuant to a care plan, for individuals receiving services from the Children with Special Health Needs Branch or meeting PHNB definitions of

³⁰ The remaining 10 percent were federal funds.

9. PATIENT TRAINING AND EDUCATION FOR DISABLED COMMUNITY RESIDENTS

The Public Health Nursing Branch (continued)

frailty or high-risk. Providers could be limited to practitioners with at least six months demonstrated experience in providing patient training and education services in the community setting.

Separate reimbursement rates could be established for patient training and education services for two classes of providers. One would be state employees and would provide reimbursement at full costs. The other would be private practitioners and would provide reimbursement at the percentage of UCR that Medicaid currently pays. Billing codes would provide for home visits, office visits, and telephone contacts.

Mandated Billing: All DOH-funded providers of patient training and education to disabled or high-risk community residents could be required to bill Medicaid for covered services.

Estimated New Federal Revenues

PHNB was not able to make a reliable estimate of the cost of providing patient training and education services, and we, therefore, were unable to estimate the amount of federal revenue that Hawaii could receive by covering PHNB patient training and education. Given that this is one of the major activities of PHNB nurses, federal revenue from Medicaid reimbursement should be substantial.

There is a potential for unintended Medicaid costs associated with the establishment of a new licensed practitioner category because the availability of this new Medicaid coverage could encourage additional providers to attempt to qualify for Medicaid patient training and education reimbursement. Since the provider qualifications could not reasonably be very restrictive, a high proportion of those attempting to qualify might succeed. However, practitioners unaffiliated with DOH may be deterred from making significant use of the available coverage by the low reimbursement that would be available to them.

10. SCHOOL-BASED MENTAL HEALTH SERVICES

Children and Adolescent Mental Health Services Division

Service Description

The Children and Adolescent Mental Health Services Division (CAMHD) is obligated by state statute, and an implementing interagency agreement, to provide mental health services to all special education students who require them.³¹ The services include diagnosis and evaluation, individual and group therapy, consultation, and crisis intervention. They are provided by qualified mental health professionals, including psychiatrists, clinical psychologists, psychiatric nurses, and clinical social workers. About two-thirds of the practitioners are employed by state-operated clinics (eight Community Mental Health Centers) and the remaining one-third are employed by private agencies (including one Community Mental Health Center), or are individual practitioners, under contract to the Division. The majority of services are provided in the school setting, although services also are provided in children's homes and in the Community Mental Health Centers and other office settings as well.

State Funding

The amount of state general revenue funds expended to provide school-based mental health services could not be estimated by the CAMHD. Total state funding for CAMHD, though, was approximately 1.6 million in fiscal year 1989-90, 93 percent of its total funding,³² and the provision of school-based mental health services is the major activity of the Division.

Service Population

All children enrolled in special education who are assessed as needing such services receive these services in accordance with their individualized education plan (IEP). In fiscal year 1988-89, 767

³¹ This obligation is limited, however, to the extent that state funding is available to cover the cost of service delivery. This limit has been and continues to be the subject of litigation.

³² The remaining 7 percent were federal funds.

³³ Effective April 1, 1990, the proportion may be somewhat higher since federal law will then require states to provide Medicaid eligibility to all children up to age 6 whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted November 21, 1989).

10. SCHOOL-BASED MENTAL HEALTH SERVICES

Children and Adolescent Mental Health Services Division (continued)

children met these criteria and received some amount of mental health services. Although no data are available on the proportion of these children enrolled in Medicaid, among Hawaii children generally, about 11 percent are enrolled in the Medicaid program.³³ We can assume that for special education students, however, the figure would be at least as high as 15 percent since there is a greater incidence of disability among low-income individuals.

Current Hawaii Medicaid Coverage Policies

Hawaii's Medicaid state plan currently provides for limited coverage of services provided by licensed psychiatrists and psychologists. Reimbursement is made at 56 percent of the provider's 1987 UCR. Visits to mental health providers that are in excess of 48 per year must be prior authorized.

Current DOH Practices with Respect to Medicaid

Although the existing Medicaid plan would permit reimbursement for a small portion of CAMHD school-based services, it has been assumed that an interagency agreement between the Departments of Health and Education makes even this amount of coverage impossible. The agreement states that DOH services will be provided in the schools free of charge.

Improved Medicaid Coverage Opportunities

Revised Benefit: Reimbursement for essentially all school-based mental health services could be obtained by expanding the definition of rehabilitative services. A new sub-category of rehabilitative services could be established for coverage of mental health services to emotionally disturbed persons provided pursuant to an individualized education plan (IEP) or other individualized plan of care developed by a multidisciplinary team, including educators, children's mental health specialists, and parents and prior authorized by CAMHD, in order to allow the person to benefit from primary or secondary education. Providers could be limited to public or private agencies, or individuals, meeting Medicaid provider standards relating to CAMHD and DOE coordination and referral agreements and the education and work experience of practitioners.³⁴

³⁴ Connecticut and Minnesota are two states that have defined the rehabilitation services benefit to specifically allow reimbursement of IEP-related mental health services.

10. SCHOOL-BASED MENTAL HEALTH SERVICES

Children and Adolescent Mental Health Services Division (continued)

This would permit reimbursement of all mental health services currently furnished to special education students by both professionals and paraprofessionals.

To maximize federal revenue for Hawaii, separate reimbursement rates could be established for three classes of providers. One would be for state-operated providers and would provide reimbursement at full cost. A second would be for private agencies and individuals that receive funds from DOH and would provide reimbursement at full costs, or at DOH costs if they are less. A third would be for private providers unaffiliated with DOH and would provide reimbursement to agencies at the regular \$14 per visit clinic rate and to individual practitioners at the percentage of UCR that Medicaid currently pays. Billing codes would be established for: diagnosis and evaluation, collateral contacts, individual or family therapy, group therapy; crisis stabilization, behavioral management services (per diem rate minus room and board), behavioral management support services, day treatment (four hours), and psychological testing.

Revised DOH/DOE Agreement: The interagency agreement between the Departments of Health and Education would have to be revised to allow for Medicaid billing. The revised agreement could state that services will be provided in the schools at no cost "to parents" and could indicate that public (and private) health insurance information and billing permission will be obtained from parents on a voluntary basis.

Mandated Billing: All DOH-funded mental health providers could be required to bill Medicaid for covered services.

Estimated New Federal Revenue

CAMHD was not able to make a reliable estimate of the cost of providing school-based mental health services. For this reason, we could not estimate how much federal revenue might be generated by reimbursing these services. This is the primary activity of CAMHD, however, and Medicaid coverage presumably would yield the state considerable federal revenue.

Should DOE be required to operate its handicapped services program as a true entitlement (as is federally mandated) and increase both the number of students enrolled as special education and the amount of related services they receive, then Medicaid expenditures for school-based mental health services would be greater than what they might be under the current situation. However, without Medicaid coverage these additional expenses would be borne fully by the state.

10. SCHOOL-BASED MENTAL HEALTH SERVICES

Children and Adolescent Mental Health Services Division (continued)

There is some small potential for unintended Medicaid costs associated with establishing a new sub-category of rehabilitative services because the availability of more flexible Medicaid coverage for mental health services could encourage additional providers to attempt to qualify for mental health rehabilitative services reimbursement. However, providers unaffiliated with DOH well may be deterred by the low reimbursement rate available to them and effectively precluded by the requirements to have coordination and referral agreements and to have a treatment plan developed by a multidisciplinary team including educators.

11. CENTER-BASED THERAPY FOR CHILDREN AND ADOLESCENTS

Children and Adolescent Mental Health Services Division

(b)(7)(C)

Service Description

The Children and Adolescent Mental Health Division also provides center-based therapy services to children with emotional problems. The services include diagnosis and evaluation, individual and group therapy, consultation, crisis intervention, and medication prescription and monitoring. They are provided by qualified mental health professionals, about two-thirds of whom are employed at eight Community Mental Health Centers operated by the Division and one operated privately. The other third are employed by numerous private agencies and individuals under contract to the Division.

State Funding

The amount of state general revenue funds expended on center-based services to emotionally troubled children and adolescents could not be estimated by CAMHD. Total state funding for the CAMHD, however, was approximately \$1.6 million in fiscal year 1989-90, 93 percent of its total funding.⁴⁵

Medicaid revenue for these services in the previous year amounted to only \$102, of which about \$45 was state funds. The funds were retained by CAMHD under an exception to the general rule that Medicaid reimbursements be deposited into the general fund.

Service Population

In fiscal year 1988-89, 945 children, about 5 percent of the target child population suggested by national data, were seen at mental health centers funded by the CAMHD. Division data indicate that at least 5 percent were enrolled in Medicaid.⁴⁶ (Due to limited funding, most sites generally refer children with any type of insurance coverage to the private sector for treatment.)

³⁵ The remaining 7 percent were federal funds.

³⁶ Effective April 1, 1990, the proportion may be somewhat higher since federal law will then require states to provide Medicaid eligibility to all children up to age 6 whose family income is less than 133 percent of poverty. 42 U.S.C. sec. 1396(a) (as amended by the Omnibus Budget Reconciliation Act of 1989 enacted November 21, 1989).

11. CENTER-BASED THERAPY FOR CHILDREN AND ADOLESCENTS

Children and Adolescent Mental Health Services Division (continued)

Current Hawaii Medicaid Coverage Policies

Center-based mental health services currently are reimbursable as a clinic services benefit, with no specific limit. The clinic reimbursement rate is set at \$14 per visit. Clinic and other mental health visits in excess of 48 per year must be prior authorized.

Current Medicaid reimbursement rates for mental health clinic visits do not appear to meet actual service costs. While Medicaid currently pays \$14 for a therapy visit, CAMHD estimates the actual average cost to be about \$58.

Current DOH Practices with Respect to Medicaid

CAMHD providers typically do not bill for all Medicaid-reimbursable services. Even assuming that only five percent of the clients were Medicaid-enrolled, reimbursement could have been made for services to about 50 recipients. Yet, in fiscal year 1988-89, Medicaid reimbursement was made for only \$102, of which the federal share was approximately \$55. This is the equivalent of only about seven visits.

Improved Medicaid Coverage Opportunities

Increased Reimbursement: Additional federal revenue could be obtained by raising reimbursement rates to reflect the actual cost of each of the services provided. Hawaii could establish separate reimbursement rates for three classes of providers: one would be state-operated facilities and would provide reimbursement at full costs; a second would be private agencies and individuals that receive funds from DOH and would provide reimbursement at full costs, or DOH costs if they were less; a third would be private providers unaffiliated with DOH and would provide reimbursement at the regular clinic visit rate of \$14. Billing codes could include assessment, individual or family therapy, group therapy, psychological testing, crisis intervention, collateral contacts, and medication monitoring.

Mandated Billing: Community Mental Health Centers and other mental health providers funded by DOH could be mandated to bill Medicaid for all covered services provided to Medicaid recipients.

11. CENTER-BASED THERAPY FOR CHILDREN AND ADOLESCENTS

Children and Adolescent Mental Health Services Division
(continued)

Estimated New Federal Revenue

CAMHD was not able to make a reliable estimate of the cost of providing center-based services. For this reason, it is not possible to estimate the federal funds that might be generated by improving Medicaid billing and reimbursement for these services. However, the number of enrollees served and the length of treatment generally required indicates substantial federal revenues.

There is no potential for unintended Medicaid costs associated with increasing rates for CAMHD-funded providers because doing so does not change the situation of other providers in any way.

12. CASE MANAGEMENT FOR THE SERIOUSLY DISABLED MENTALLY ILL

Adult Mental Health Division

Service Description

Case management services for individuals assessed as being seriously disabled due to mental illness (SDMI) are provided by social workers employed by nine Community Mental Health Centers. Eight of the Centers are state-operated and the ninth is a private agency under contract to the Adult Mental Health Division (AMHD). The services include client assessment and services planning, monitoring and coordinating service delivery, and client support and advocacy. They are provided over the telephone, at the clinics, in clients' homes, and in various other settings.

State Funding

The amount of state general revenue funds expended on case management services to SDMI clients could not be estimated by AMHD. Total state funding for AMHD, though, was approximately \$30 million in fiscal year 1988-89, over 95 percent of its total funding.³⁷

Service Population

In fiscal year 1988-89, AMHD provided case management services to about 1,100 individuals with disabling mental illness, about 12 percent of the 9,000 individuals the Division estimates make up Hawaii's SDMI population. Among those served, AMHD records indicate that 52 percent were Medicaid-enrolled.

Current Hawaii Medicaid Coverage Policies

Case management services for the seriously disabled mentally ill are not covered under Hawaii's Medicaid program.

Medicaid Coverage Opportunities

New Benefit: Reimbursement for case management services to the seriously mentally ill could be obtained by adding a targeted case management benefit to the state Medicaid plan. The benefit could be defined for adults determined by AMHD to be seriously disabled as a

³⁷ The remaining 5 percent were federal funds.

12. CASE MANAGEMENT FOR THE SERIOUSLY DISABLED MENTALLY ILL

Adult Mental Health Division (continued)

result of mental illness.³⁸ Federal law permits designation of case management providers for the mentally ill so that provider agencies could be limited to Hawaii's Community Mental Health Centers. The reimbursement rates would be at full costs and billing codes would account for home and other off-site visits as well as telephone and office contacts.³⁹

Mandated Billing: All providers of case management services to the seriously disabled mentally ill could be required to bill Medicaid for covered services.

Estimated New Federal Revenues

AMHD was not able to make a reliable estimate of the cost of providing case management services. As a result, we could not estimate the amount of federal revenue that Hawaii might expect as a result of making Medicaid reimbursement available for case management services to the seriously mentally ill population. However, the number of enrollees served and the chronic nature of their conditions indicate substantial federal funds.

There would be no potential for unintended Medicaid costs associated with establishing this targeted case management benefit because it would be limited to case management clients of CMHCs and provided only by CMHC staff.

³⁸ Currently at least 12 states reimburse case management services for the seriously disabled mentally ill population under a targeted case management benefit. Overall, at least 26 states have amended their state plans to provide reimbursement of case management services under the targeted case management benefit. Eleven of these states use multiple targeted case management subcategories to best meet the needs of diverse targeted groups.

³⁹ A number of states reimburse case management services based on 15-minute intervals of time. Others use monthly capitation rates, but the validity of these has been seriously questioned both by the states and HCFA.

13. SERVICES FOR THE SERIOUSLY DISABLED MENTALLY ILL (SDMI)

Adult Mental Health Division

Service Description

The Adult Mental Health Division (AMHD) funds a range of rehabilitative services to individuals assessed as being seriously disabled due to mental illness. The services include individual and group skill building (day treatment), medication prescription and evaluation, consultations, crisis stabilization, and respite care. The services are provided by multi-disciplinary teams, made up of psychiatrists, clinical psychologists, nurses, and clinical social workers who are employed by nine Community Mental Health Centers (CMHC). Eight of the Centers are state-operated and the ninth is a private agency under contract to the Division. Day treatment services are provided at the clinic sites, but both crisis intervention and respite care services are provided in a variety of settings, including the client's home.

State Funding

The amount of state general revenue funds expended to provide services to seriously disabled mentally ill (SDMI) clients could not be estimated by AMHD. Total state funding for AMHD, though, was approximately \$30 million in fiscal year 1988-89, over 95 percent of its total funding.

Total Medicaid reimbursement for services to the SDMI was about \$22,000 in that year, of which \$10,120 was provided with state funds. The Medicaid reimbursements received were retained by the AMHD under an exception to the general rule that requires Medicaid reimbursements to be deposited to the general fund.⁴⁰

Service Population

In fiscal year 1988-89, AMHD served about 1,100 individuals with disabling mental illness, about 12 percent of the 9,000 individuals estimated by AMHD to require SDMI services. Among those served, Division records indicate that 52 percent were Medicaid-enrolled.

Current Hawaii Medicaid Coverage Policies

Center-based mental health services provided to the seriously disabled mentally ill is covered under the clinic services benefit -- although only one service can be billed per day and visits in excess of 48 per year require prior authorization. The current reimbursement rate for a mental health clinic visit is \$14 per day.

⁴⁰ H.S.R. 37-31, 37-40, 37-54 (1985).

14. CENTER-BASED THERAPY FOR THE ADULT MENTALLY ILL

Adult Mental Health Division

Service Description

The Adult Mental Health Division (AMHD) also provides center-based therapy services to adults with acute mental health problems. The services include diagnosis and evaluation, individual and group therapy, consultation, crisis intervention, and medication prescription and monitoring. They are provided by qualified mental health professionals at the Community Mental Health Centers, as well as by numerous private agencies and individuals that receive state AMHD funds. Nearly all of these services are provided at the clinic site, although crisis intervention could take place in the client's home.

State Funding

The amount of state general revenue funds expended on center-based therapy to adults with acute mental health problems could not be estimated by AMHD. Total state funding for AMHD, though, was approximately \$30 million in fiscal year 1988-89, over 95 percent of its total funding.

Service Population

AMHD served about 2,160 adults in need of short-term mental health services in fiscal year 1988-89, about 35 percent of all adults needing such services according to AMHD estimates. Program statistics indicate that only about five percent of adults receiving short-term therapy are Medicaid-enrolled because, due to limited funding, many sites refer those with insurance coverage to other providers for treatment.

Current Hawaii Medicaid Coverage Policies

Nearly all center-based services are already covered under Hawaii's existing clinic services benefit category, with no specific limit. The clinic reimbursement rate is set at \$14 per visit. Clinic and other mental health visits in excess of 48 per year must be prior authorized.

Current Medicaid reimbursement rates for mental health clinic visits do not appear to meet actual service costs. While Medicaid currently pays \$14 for a therapy visit, AMHD estimates the actual average cost to be about \$58.

Current DOH Practices with Respect to Medicaid

AMHD providers are not billing Medicaid for any center-based therapy services to adults with acute problems.

14. CENTER-BASED THERAPY FOR THE ADULT MENTALLY ILL

Adult Mental Health Division (continued)

Improved Medicaid Coverage Opportunities

Increased Reimbursement: Additional federal revenue could be obtained by raising reimbursement rates to reflect the actual cost of each of the services provided. Hawaii could establish separate reimbursement rates for three classes of providers: one would be state-operated facilities and would provide reimbursement at full costs; a second would be private agencies and individuals that receive funds from DOH and would provide reimbursement at full costs, or DOH costs if they are less; a third would be private agencies and individuals unaffiliated with DOH and would provide reimbursement at the regular clinic rate (\$14 per visit) already available to them. Billing rates could include assessment, individual and family therapy, group therapy, collateral contacts, crisis intervention, psychological testing, and medication monitoring.

Mandated Billing: Community Mental Health Centers and other DOH-funded mental health providers could be mandated to bill Medicaid for all covered services provided to Medicaid recipients.

Estimated New Federal Revenue

AMHD was not able to make a reliable estimate of the cost of providing center-based services to adults with acute mental health problems. For this reason, we could not estimate how much federal revenue Hawaii might expect to receive as a result of improving Medicaid billing and reimbursement for these services.

There is no potential for unintended Medicaid costs associated with increasing rates for AMHD-funded providers because doing so does not change the situation of other providers in any way.

be changed. The only action that would need to be taken to implement the clinic options is the establishment of discrete clinic classifications and rates in the clinic section of the administrative rules.

- . Hawaii does not restrict ancillary therapists' services to licensed practitioners in its state plan; it does this administratively. Implementing the changes necessary to reimburse DOH providers for related special education services, therefore, only would require expanding the existing benefit category section for ancillary therapists' services in the Medicaid program's administrative rules to include a special sub-category of IEP-related services furnished by licensed therapists as well as supervised assistants paid according to a negotiated rate schedule. (Reimbursement for the more general sub-category of "licensed practitioners only" would continue to be set at the percentage of UCR that Medicaid currently pays.)

The remaining benefit and reimbursement options *would* require the submission of state plan amendments.

- . The category of targeted case management services would have to be covered with separate sub-categories for each of the five target groups proposed. Rates would be negotiated.
- . The already-available rehabilitative services category would have to be expanded to permit coverage of three sub-categories of service: mental health rehabilitative services for adults, mental health rehabilitative services for children, and the existing physical rehabilitative services. Rates for all three subcategories of service would be based on negotiation.
- . The existing other licensed practitioner category would have to be broadened to allow for coverage of certain nurses' services as well as for psychologists' services. The nurses' services sub-category would be reimbursed according to a negotiated rate. (Reimbursement for the sub-category of psychologists' services would continue to be set at the percentage of UCR that Medicaid currently pays.)

CHAPTER 3

ELIGIBILITY AND ENROLLMENT OPTIONS

Introduction

This chapter describes and assesses options available to Hawaii for expanding eligibility and enhancing efforts to enroll potentially eligible persons in Medicaid. The options are assessed for their potential to maximize federal financing in the State's efforts to insure health care coverage and adequate access for the uninsured "gap groups." Based on this assessment, we conclude that Hawaii should:

- . Expand eligibility to include all children age 4 to 8 up to the poverty level.
- . Raise the Medicaid income eligibility standard to the maximum allowed under federal law where it would not incur additional welfare expenditures.
- . Undertake efforts to enhance enrollment in existing and future Medicaid eligibility categories where it would not incur additional welfare expenditures.
- . Ensure that the State Health Insurance Program (SHIP) is well coordinated with Medicaid to ensure maximization of federal dollars, continuity of coverage for gap group members, and continuing access to health care providers.

These recommendations are summarized in Exhibit 3.1.

This chapter begins with an overview of current Medicaid eligibility in Hawaii. We then describe opportunities available to the State for expanded eligibility and enrollment, including estimated caseloads and costs. The final sections of the chapter assess the options and make recommendations.

Current Medicaid Eligibility in Hawaii

The Hawaii Medicaid program currently covers most optional eligibility categories for which federal reimbursement is available. In order for states to receive federal matching funds under Medicaid, they must cover certain "mandatory" eligibility groups. States also can cover, with a federal match, certain "optional" groups. Hawaii covers most of the latter, as well as additional persons enrolled in the General Assistance program (GA) who are entirely state funded.

Exhibit 3.2 illustrates current Medicaid eligibility in Hawaii, including both the "federal/state" Medicaid program for which federal matching funds are available and the "state-only" Medicaid program which is funded entirely with state dollars. The chart shows two major factors determining

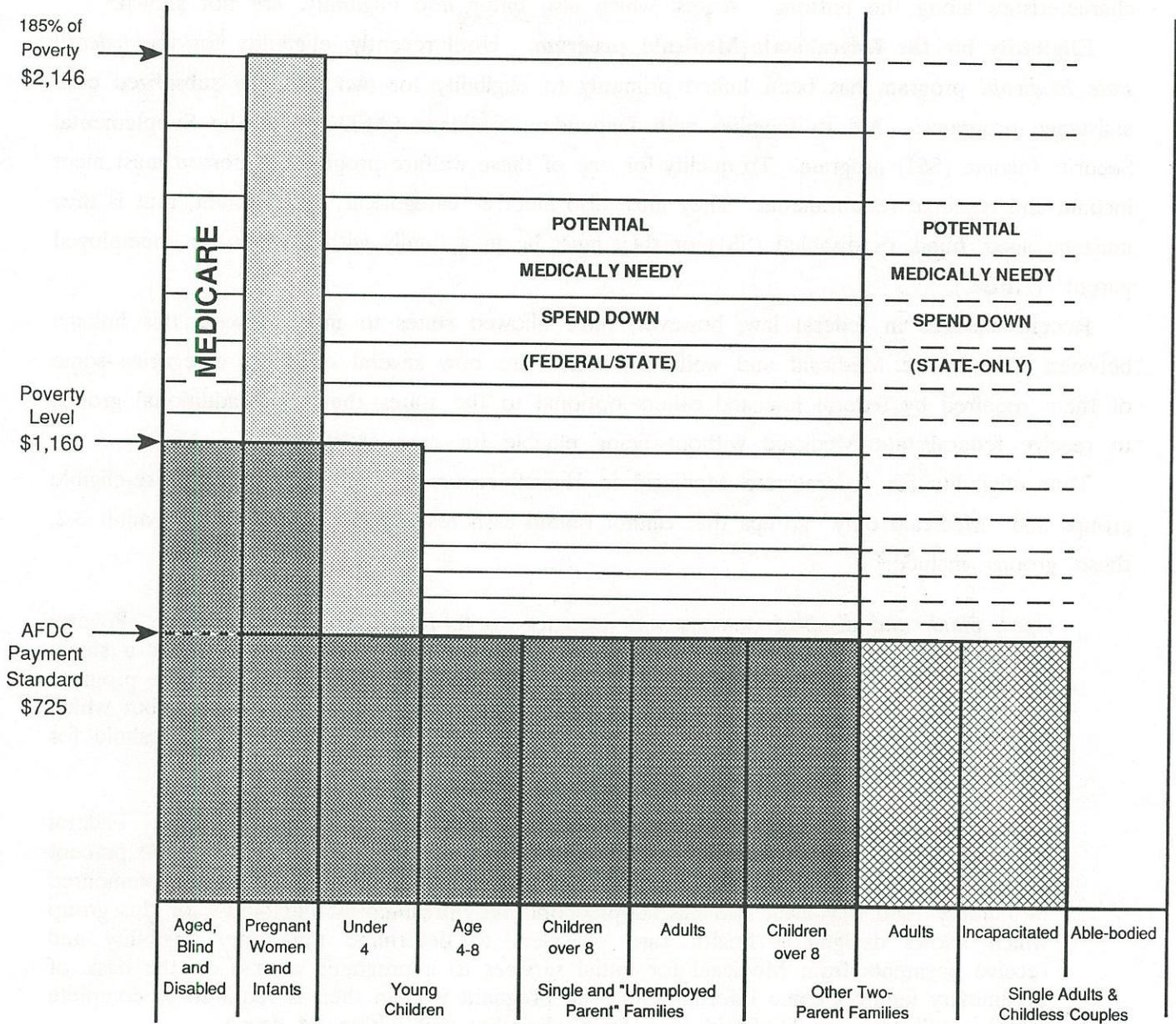
Exhibit 3.1

SUMMARY OF RECOMMENDATIONS FOR MEDICAID ELIGIBILITY EXPANSION

Recommendation	Population Affected	Estimated Number of Persons Covered	Estimated Cost (FY 1990-91)	
			Federal	State
Expand eligibility to include all children age four to eight up to the poverty level.	Young children in families with incomes under \$1,160 per month (family of four) but above the AFDC payment standard (\$725 per month).	2,500	\$936,500	\$707,700
Raise the Medically Needy income eligibility standard to the maximum allowed under federal law (133-1/3 percent of AFDC payment standard) where it would not incur additional welfare expenditures.	Primarily single-parent families and older children who would be eligible for AFDC except that their income is too high. Offers ongoing Medicaid coverage for persons with incomes up to \$964 per month for a family of four.	1,550	\$928,600	\$791,100
Undertake efforts to enhance enrollment in existing and future Medicaid eligibility categories where it would not incur additional welfare expenditures.	Persons who meet income, asset, and categorical requirements for Medicaid but have not enrolled. Focuses on pregnant women, infants, and young children who can obtain Medicaid but cannot qualify for cash assistance.	--	--	--
Ensure that SHIP is well coordinated with Medicaid to ensure maximization of federal dollars, continuity of coverage for gap group members, and continuing access to health care providers.	Persons likely to move on and off Medicaid as circumstances and family income change.	--	--	--

MEDICAID AND THE POOR IN HAWAII

(Income Levels for a Family of Four in 1989)



FEDERAL/STATE MEDICAID:

- Categories Currently Covered
- Categories Recently Authorized

STATE-ONLY MEDICAID:

- Categories Currently Covered

Note: This is a simplified representation of eligibility. Income thresholds are net of allowable deductions including child care expenses, work related expenses, and certain work incentive disregards. Assets also enter into eligibility.

eligibility: monthly family income along the left-hand side, and demographic (or "categorical") characteristics along the bottom. Assets, which also enter into eligibility, are not shown.¹

Eligibility for the federal/state Medicaid program. Until recently, eligibility for the *federal/state Medicaid* program has been linked primarily to eligibility for two federally subsidized cash assistance programs: Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) program. To qualify for one of these welfare programs, a person must meet income and resource requirements. They must also meet a "categorical" requirement, that is they must be aged, blind, or disabled (SSI) or they must be in a family with a single or unemployed parent (AFDC).

Recent changes in federal law, however, have allowed states to move beyond this linkage between federal/state Medicaid and welfare. There are now several eligibility categories--some of them required by federal law and others optional to the states--that allow additional groups to receive federal/state Medicaid without being eligible for cash assistance.

Thus eligibility for federal/state Medicaid in Hawaii covers a combination of welfare-eligible groups and "Medicaid only" groups that cannot obtain cash assistance. As shown in Exhibit 3.2, these groups include:²

- . *Aged, blind, and disabled* persons with incomes up to the federal poverty level. Poverty in Hawaii is about \$1,160 per month for a family of four, and about \$572 for a single individual. Note that this group is also eligible for Medicare (federal medical care program for the aged and disabled), which is available regardless of income and assets, but which excludes several benefits that are covered by Medicaid. The poverty level threshold for this group is optional, and was implemented by Hawaii in January 1989.³
- . *Pregnant women and infants* with incomes up to 185 percent of the poverty level. Federal Medicaid law requires coverage of this group up to the poverty level,⁴ but the 185 percent income standard was adopted at Hawaii's option. The 185 percent standard was implemented in January 1990. (Hawaii also has adopted optional "presumptive eligibility" for this group which allows designated health care providers to determine temporary eligibility and receive payments from Medicaid for initial services to a pregnant woman on the basis of preliminary family income information. The pregnant woman then is required to complete a full application for Medicaid at a DHS eligibility unit within 14 days.)
- . *Young children* with incomes up to the poverty level. Federal Medicaid law mandates coverage for all young children (up to age eight) with incomes up to the State's AFDC Payment Standard, but raising eligibility to 100 percent of the federal poverty level is optional. Hawaii implemented this option for children up to age four in January 1990. While the legislation authorizing this expansion allowed coverage for "older children to the extent permitted under federal Medicaid rules" (i.e., up to age eight), funding was authorized only for children up to age four. The State, therefore, still has not implemented the option to increase the age threshold to eight for this group.

- *Single- and "unemployed-" parent families* with incomes (net of allowable deductions) up to the state AFDC Payment Standard. This federally mandated eligibility group automatically qualifies for Medicaid by virtue of eligibility for AFDC. To obtain AFDC, the family must have an absent or incapacitated parent, or the breadwinner must be "unemployed," meaning he/she worked in the recent past, but is currently working less than 100 hours per month. States are allowed to set their own AFDC income eligibility standards. In July of 1988, the Hawaii AFDC income standards were raised and linked to increases in the poverty level. Persons are now eligible if their income (net of allowable deductions) is no more than 62.5 percent of the poverty level or about \$725/month for a family of four.⁵
- *Other children* with incomes up to the AFDC Payment Standard. These are children who meet the AFDC income and assets tests, but do not qualify for AFDC because they are in two-parent families (or are not currently living with a parent). Federal law requires Medicaid coverage for these children up to age eight (see above), but Hawaii has also opted to cover older children. (In Hawaii, these two-parent families generally can obtain cash assistance through the state-financed General Assistance program. General Assistance provides *state-only* Medicaid to the parents of these children.)
- Persons qualifying as *Medically Needy spend down* recipients are those who would be eligible for categorical coverage but have incomes that are too high. They can qualify for Medicaid on a temporary basis (six months) if their income is no more than the AFDC Payment Standard after their medical expenses are subtracted. This process of subtracting incurred medical bills from gross income is called "spend down." The Medically Needy program is optional, and is generally useful to near-poor persons who incur large medical expenses. Hawaii has the option, which it has not taken, of raising the Medically Needy standard higher than it is now. Medically Needy recipients do not receive cash assistance.

Eligibility for the state-only Medicaid program. Exhibit 3.2 also shows eligibility for the *state-only Medicaid* program which is associated with the General Assistance cash program. Income and asset requirements are the same for state-only Medicaid as for the AFDC portion of the federal/state Medicaid program. State-only Medicaid extends medical coverage to adults in intact families, as well as single adults and childless couples who cannot work because of an incapacitating condition. Note that persons in these categories can "spend down" for state-only Medicaid eligibility just as can the federal/state Medicaid population. This provision allows temporary coverage for persons whose incomes are too high for ongoing coverage, but who incur large medical bills.

Because the state-only Medicaid program is entirely state-funded, it is not subject to federal Medicaid rules and regulations. Thus, eligibility and benefit parameters for state-only Medicaid are set totally at the option of Hawaii. The State has chosen to mirror the federal/state Medicaid program for these populations, and to administer the two components as a single program. The only major difference is that the federal government cannot be billed for any portion of the costs of this program.

Note that the remaining population category in Exhibit 3.2, able-bodied single adults and childless couples, cannot obtain *either* federal/state or state-only Medicaid, regardless of their income.

The state-only Medicaid program is similar to the new State Health Insurance program (SHIP) currently being developed by DOH in that it provides health care coverage at full state cost for low income populations. SHIP, however, will cover populations with higher incomes including those not covered by either of the State's Medicaid programs (i.e., up to 300 percent of poverty), but will offer a much more limited benefit package.

Recent Hawaii initiatives. Many of the optional eligibility categories described above were implemented in Hawaii recently, reflecting a series of efforts already undertaken by the State to enhance eligibility and tap into additional federal dollars. Exhibit 3.3 summarizes these optional expansions.

Opportunities for Enhanced Eligibility and Enrollment

Three options are available to Hawaii for expanding coverage under the federal/state Medicaid program without incurring additional state expense for cash welfare programs:

- . Coverage of children age four to eight in families with incomes up to the poverty level.⁶
- . Elevation of the Medically Needy Income standard to 133-1/3 percent of the AFDC Payment Standard.
- . Increased enrollment of persons who are eligible for Medicaid-only categories.

This section describes each of the three major options for expanded Medicaid-only (i.e., without cash assistance) coverage. The options then are assessed in the next section.

Coverage of children age four to eight up to poverty. Federal law allows states to increase Medicaid income eligibility to the poverty level, or about \$1,160 a month for a family of four, for children up to age eight. In the 1989 session, the Hawaii Legislature extended coverage to this group, but authorized funding only for children up to age four. Thus, the State could extend coverage to the poverty level of all children up to age eight if funds were made available, as illustrated in Exhibit 3.4.

This option would cover approximately 2,500 children at any given point in time, representing a 3.2 percent increase in the current Medicaid caseload (Exhibit 3.5). Approximately 3,000 children in total would be covered over the course of the year. (These estimates are *approximations*, based on a Lewin/ICF analysis of Hawaii Current Population Survey data pooled from the years

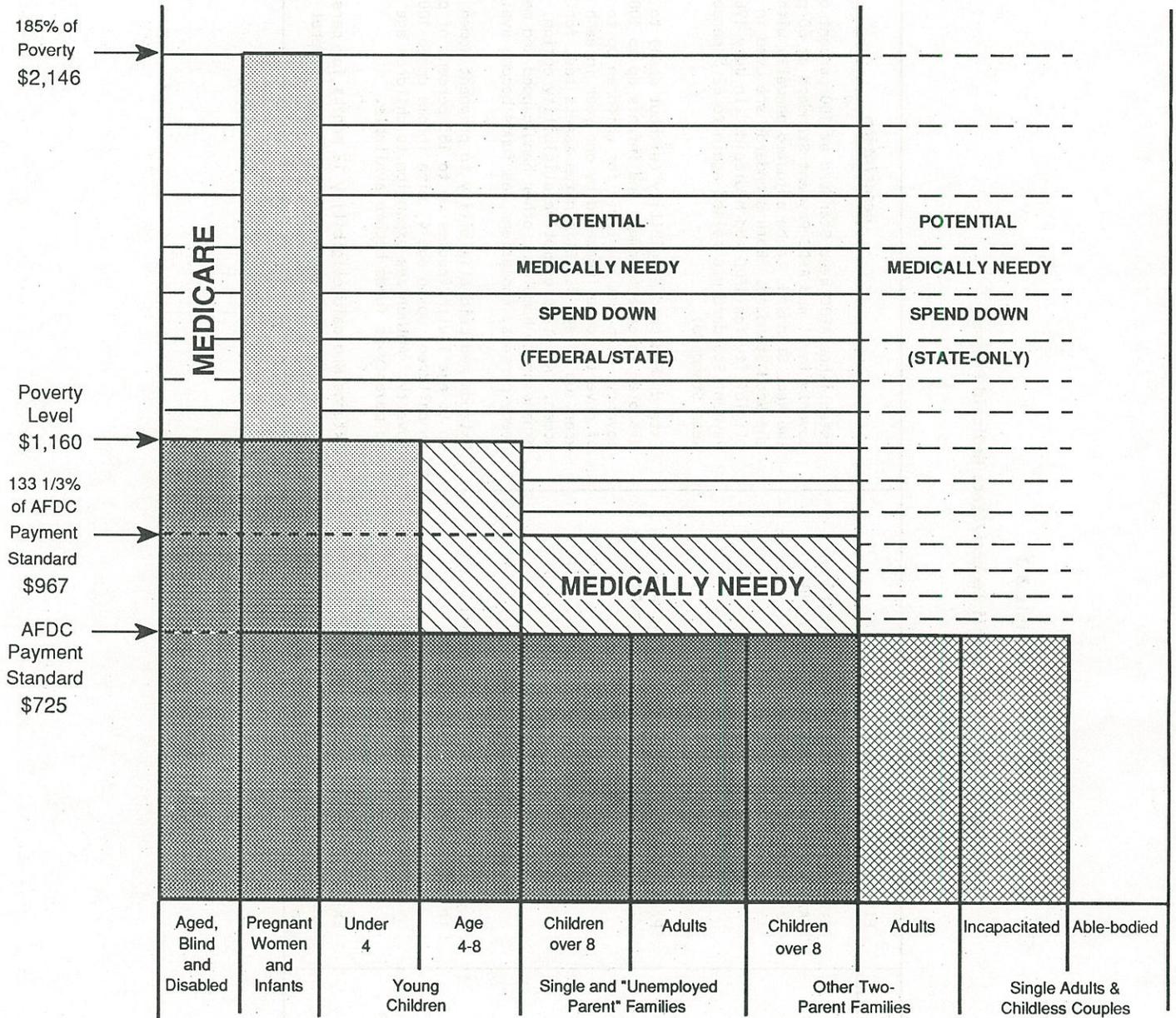
Exhibit 3.3

Recent Expansions in the Hawaii Federal/State Medicaid Program

Implementation Date	Eligibility Category	Description
July 1988	Aid to Families with Dependent Children (AFDC) income eligibility levels (HB 3243, Act 327, SLH 1988)	Establishes AFDC Need Standard at 100 percent of the poverty level and AFDC Payment Standard at 60 percent of the Need Standard, to be adjusted annually with changes in the Need Standard. Both standards are used in determining eligibility for AFDC and Medicaid. In July 1989, the Payment Standard was raised again to 62.5 percent of the Need Standard.
January 1989	Pregnant women, infants, elderly, and disabled (SB 3088, Act 296, SLH 1988)	Extends Medicaid eligibility (without cash) to elderly, disabled, pregnant women, and infants up to 100 percent of poverty, with the age limit for children up to 100 percent of poverty to be increased by one year in each subsequent year, up to age 4. Eliminates assets test for pregnant women. Adopts presumptive eligibility option. Authorizes expansion to homeless, other handicapped and medically needy persons, and aliens, as funds become available.
January 1990	Pregnant women and infants; children up to age 4 (Act 393, SLH 1989)	Extends Medicaid eligibility to pregnant women and infants up to age 1 with incomes up to 185 percent of poverty and to children, up to age 4, with income up to 100 percent of poverty. Authorizes expansion to children age 4 to 8 up to poverty as funds become available.
April 1990	Extended Medicaid eligibility for AFDC recipients who lose cash due to increase in earnings (federal Family Support Act)	Extends Medicaid eligibility 12 months for persons who lose AFDC due to earnings (required by federal Family Support Act of 1988).

MEDICAID AND THE POOR IN HAWAII

(Income Levels for a Family of Four in 1989)



FEDERAL/STATE MEDICAID:

- Categories Currently Covered
- Categories Recently Authorized
- Remaining Optional Categories

STATE-ONLY MEDICAID:

- Categories Currently Covered

Note: This is a simplified representation of eligibility. Income thresholds are net of allowable deductions including child care expenses, work related expenses, and certain work incentive disregards. Assets also enter into eligibility.

Exhibit 3.5

Caseload and Cost Estimates for Medicaid Eligibility Expansions
Hawaii, FY 1990-91

	<u>Projected New Enrollment</u>		Percent Increase Over Current* Enrollees	<u>Projected Cost of Expansion**</u>			Estimated Percent Increase in State Expenditures
	<u>Any Point in Time</u>	<u>Total During Year</u>		<u>Total</u>	<u>Federal</u>	<u>State</u>	
Children Age 4-8 Up to Poverty	2,500	3,000	3.2%	\$1,734,200	\$ 936,500	\$ 797,700	0.9%
Medically Needy @ 133-1/3% of AFDC Payment Standard							
New Enrollees	1,550	2,350	2.0	1,619,900	874,700	745,200	
New Spenddown expense				99,800	53,900	45,900	
Total				1,719,700	928,600	791,100	0.9
Total Expansion	4,050	5,350	5.2%	\$3,453,900	\$1,865,100	\$1,588,800	1.8%

* Current enrollees include federal/state and state-only Medicaid recipients.

** Includes estimated administrative costs. Costs are based on a full year of implementation with full enrollment of estimated caseload. In actuality, enrollment and costs in first year can be expected to be lower as start up in the first year is usually slow. Costs projected assuming an annual increase in expected costs of 6 percent (estimated average annual change in per capita spending for categorically needy Medicaid recipients in Hawaii, 1984-1988). Federal and state cost share estimates assume a 54 percent federal match. Actual match may vary depending on mix of services and level of administrative costs.

Source: Estimates developed by Lewin/ICF and Fox Health Policy Consultants from Current Population Survey data and DHS Medicaid data. See Appendix C.

1984, 1985, 1987, and 1988. See Appendix C for a full discussion of data limitations and assumptions used in the analysis).

Total cost for this expansion is estimated at \$1.7 million, entailing \$798,000 in state expenditures and \$936,000 in federal dollars (including estimated administrative costs). The new state funds would be about a 1 percent increase in projected state dollars needed for Medicaid in fiscal year 1990-91.

These figures reflect a year of full implementation in estimated fiscal year 1990-91 dollars. In actuality, the first year of implementation will likely cost less than estimated as start-up in the first year is usually slow. (See Appendix C for a full discussion of cost estimates.)

Elevation of the medically needy income standard. Federal law allows states to set their Medically Needy income eligibility standard as high as 133-1/3 percent of the State's AFDC Payment Standard, as illustrated in Exhibit 3.3. Currently the Medically Needy standard in Hawaii is *the same as* the AFDC Payment Standard. Persons with monthly incomes above the AFDC standard can qualify for Medicaid only if they incur enough medical expenses to "spend down" to the AFDC line -- about \$725 for a family of four. By raising the Medically Needy standard to \$967 (133-1/3 percent of the Payment Standard) persons with incomes *between* \$725 and \$967 could qualify on an ongoing basis.

This option would cover an estimated 1,550 persons at any given point in time, representing a 2.0 percent increase over the current Medicaid caseload (Exhibit 3.5). About 2,350 persons in total would qualify over the course of the year due to turnover in the caseload. This estimate assumes that children up to age eight are already covered through the previous option.

The new Medically Needy population would be comprised primarily of children over age eight and single parents. Some "unemployed" parents in intact families also may qualify. The elderly and disabled are eligible as well, but will already qualify under the poverty income threshold as shown in Exhibit 3.4. Those that currently "spend down" for Medicaid, however, would qualify with fewer medical expenses. (Despite the poverty income standard, the aged and disabled with incomes higher than poverty must still spend down to the Medically Needy level, i.e., the AFDC Payment Standard currently at 62.5 percent of poverty.)

Estimated total cost of this option is \$1.7 million, \$791,000 of which would be state funds and \$929,400 of which would be new federal dollars. The new state funds would be about a one percent increase in projected state dollars needed for Medicaid in fiscal year 1990-91. About \$46,000 of the state amount is the estimated cost of new expenditures for current aged and disabled "spend down" cases who would qualify with fewer incurred medical expenses, thereby increasing the portion of their expenses paid by Medicaid.

Increased enrollment of persons eligible for “Medicaid Only.” The third major option available to Hawaii is to increase enrollment of currently eligible persons, particularly those in new categories that do not qualify for cash assistance. These federal/state Medicaid-only categories include:⁷

- . Aged and disabled up to 100 percent of poverty
- . Pregnant women and infants up to 100 percent of poverty (increased to 185 percent of poverty in January 1990).
- . Young children up to poverty (implemented January 1990).

Collectively, these new categories are referred to in Hawaii as MOMI (Medicaid Options for Mothers and Infants).

The issue of underenrollment in Medicaid. Enrollment in Medicaid in most states is well below the number of persons who can qualify for the program based on their income, assets, and “categorical” status. Nationally, only about 73 percent of nonelderly persons who are technically eligible for federal/state Medicaid are actually registered for the program.⁸ Household surveys in Colorado and Florida have confirmed this pattern at the state level, revealing that only about 65-75 percent of the nonelderly who meet program eligibility requirements are signed up.⁹

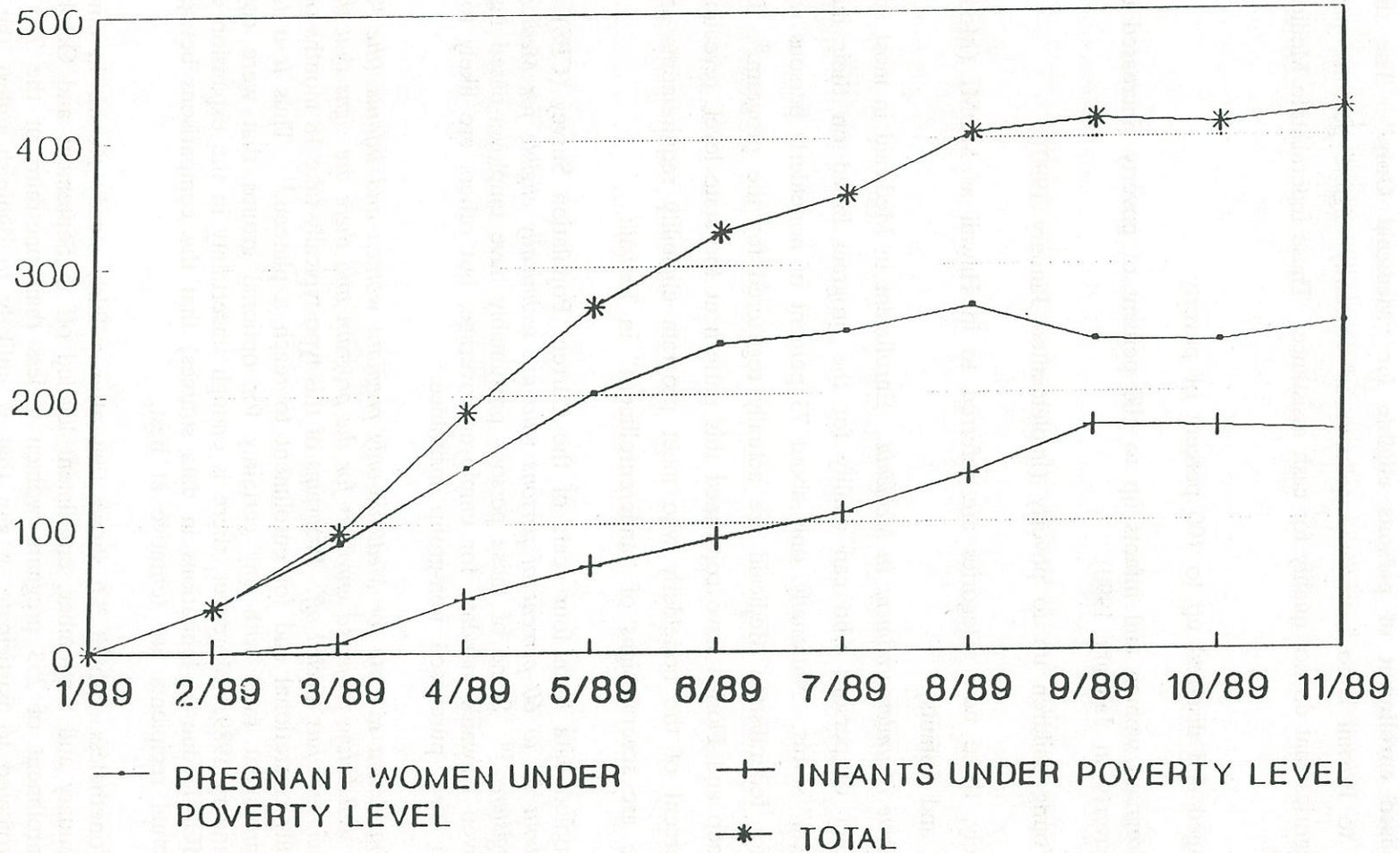
There are several signs of “underenrollment” in Hawaii:

- . Pooled data from four years of the Current Population Survey (CPS) indicate that *only about 50 to 60 percent of persons who are technically eligible for Medicaid in Hawaii are registered.*¹⁰ Some of these persons presumably have employer-based insurance, especially given Hawaii’s mandate for employer coverage, but others are likely to be uninsured or to have purchased non-group insurance.
- . *Enrollment to date for Medicaid-only pregnant women and infants (the “MOMI” initiative) is well below projected enrollees for the program and there are signs that the increase in new recipients has leveled off.* Programs of this type typically take 18 months or more to become fully operational and for enrollment to reach a plateau.¹¹ Thus *it is too early* to assess enrollment rates with any certainty for optional groups that were covered only as of January 1989. Moreover, there is enough uncertainty in the expansion estimates used for MOMI (due to limitations in data sources) that the comparisons between projected and actual recipients are tentative at best.

Nonetheless, Exhibit 3.6 shows that after a fairly steady growth in enrollments between January and September, enrollment leveled off in September and October. The current enrollment of 253 pregnant women is less than one-third of the 730 pregnant women projected to participate, a gap that is unlikely to diminish unless the upward trend in enrollment resumes. This apparent “leveling off” is also unlike the experience with new Medicaid-only options in other states, which have typically seen steady growth throughout the first 12 to 18 months of implementation.

EXHIBIT 3.6

**PREGNANT WOMEN AND INFANTS ENROLLED IN NEW
FEDERAL/STATE MEDICAID-ONLY CATEGORIES IN HAWAII
JANUARY - NOVEMBER 1989**



SOURCE: Hawaii MMIS Reports, XIXRR616
 "Title XIX Eligible Recipients Report"
 for period 1/1/89 through 11/1/89.

Some health care providers report that many of their low-income pregnant clients have neither private insurance nor Medicaid. In the prenatal clinic at the Kalihi-Palama Health Clinic, for example, almost all of the patients are below poverty: 80 percent of the pregnant women cared for between January and September 1989 had reported annual incomes below \$5,000 and 89 percent had annual incomes below \$10,000. Only about a third of the prenatal patients during that period had Medicaid, however, and another one-half reported no insurance coverage.¹²

Factors contributing to underenrollment. Experience in other states has shown that underenrollment in Medicaid can be attributed, in part, to the traditional linkage between cash welfare and Medicaid eligibility.¹³ State Medicaid programs are often set up to enroll welfare recipients and have few or no mechanisms to reach Medicaid-only target populations. Medicaid enrollment takes place in the welfare office and through a process that assumes applicants are interested in and seeking cash assistance. Low-income working persons who never have applied for public assistance may be unaware that they can qualify for Medicaid coverage without also seeking cash. Even those who are aware may avoid registering for Medicaid because of a perceived stigma associated with the “welfare office.”

This appears to be an issue for Hawaii as well. Persons seeking to register in a Medicaid-only category are subject to the same enrollment procedure as persons applying for cash assistance. DHS eligibility units in Hawaii are oriented toward the full package of cash and medical benefits for potential clients, reflecting a recent initiative in the state to offer a “single point of access” for persons in need of multiple supports. Eligibility workers formerly specialized by type of assistance (e.g., AFDC, Food Stamps, and Medicaid), but are now trained to enroll persons in the full range of programs. They are assisted in this effort by a consolidated application form and computerized eligibility determinations. The drawback of this approach is that the consolidated application form is 42 pages long, entailing an involved and complex process for a person who is interested only in Medicaid. Much shorter forms, as well as procedures for “off-site” registration, can and have been used by other states for Medicaid-only applicants.¹⁴

While there have been several DHS initiatives to encourage enrollment under MOMI, they have been limited in scope so far. An outreach campaign (posters, radio ads, etc.) was undertaken at the beginning of program implementation, but funding for the effort was limited to \$30,000 and there is little current activity while the department awaits approval for staff to coordinate additional outreach efforts.

DHS also implemented an optional “presumptive eligibility” provision designed to let health care providers register pregnant women for Medicaid temporarily while DHS undertakes formal confirmation and processing of their eligibility status. This provision is designed to encourage early enrollment of pregnant women. These women are given 14 days after they receive presumptive

eligibility status from the provider to apply formally for the program, and DHS is then given 45 days to process the forms. Medicaid claims for services provided within this period are paid regardless of the eventual eligibility status of these patients.

Presumptive eligibility has had limited reach, however, Federal regulations allow only organizations that receive certain types of federal funds to be designated “presumptive eligibility providers.” There are relatively few of these in Hawaii, and to date designated providers are limited to the island of Oahu, and to Hilo on the Big Island. DHS currently is attempting to recruit qualified providers on the other islands.

Where presumptive eligibility is in place, it has reportedly met with mixed success. Providers report that many women referred to DHS for eligibility confirmation fail to register at a DHS eligibility unit within the required 14 days. While this could not be confirmed with available data, it is consistent with the overall low enrollment for this target population.

Ways to enhance enrollment. Enrollment in Medicaid-only options can be enhanced through at least three mechanisms. First, a “short form” can be developed for persons interested in applying for Medicaid coverage but unlikely to qualify for cash benefits. Other states have found that the information needed for Medicaid-only coverage, particularly in the case of pregnant women and infants for whom no asset information is required, can take up to as few as 2 to 5 pages, compared to the 42 pages now used in the DHS consolidated form.¹⁵ The short form could be used for persons who are only seeking medical benefits. It would include “screener” questions to determine if a person may be eligible for other programs as well, in which case referral could be made to the conventional application process and consolidated form.

Second, persons trained in “short form” Medicaid enrollment could be placed in key DOH-funded clinics and other health care settings where the Medicaid-only population is likely to obtain care. These out-stationed workers could be either current DHS staff specializing in Medicaid enrollment, or non-DHS clinic staff trained and certified to complete the application process for DHS. Some of these workers could work in more than one clinic setting, attending some of the smaller clinics, for example, on the days when target populations are present (e.g., pregnant women, children).

The goal of this arrangement would be to make Medicaid-only readily available to a population that may otherwise be unlikely to consider public assistance or make use of a DHS application unit. This would include “presumptively eligible” maternity patients who are failing to follow-up and register with DHS on their own. To avoid the stigma problem, the Medicaid-only package could be presented and discussed as an insurance program rather than “welfare,” an approach other states have reinforced by using a non-Medicaid title to identify and publicize the program.

(As discussed later, this outstationed eligibility function could be combined with eligibility enrollment for SHIP, thereby coordinating eligibility for the two programs and potentially making the effort more affordable for DHS and DOH.)

Third, DHS could continue its efforts to recruit additional providers, particularly on neighbor islands, who can certify maternity patients as “presumptively eligible” for Medicaid. Presumptive determinations are likely to be less effective than the outstationed worker approach because they entail two sets of paperwork in two different locations, one of which (a DHS eligibility unit) has the broader welfare-orientation discussed above. Nonetheless, the State may want to use both outstationed workers and presumptive eligibility providers as a way of maximizing the number of locations where sign-up is possible and to encourage early prenatal care.

According to federal law, to qualify as a presumptive eligibility provider, a provider must receive funds under the Migrant Health Centers, Community Health Centers, or Maternal and Child Health block grant programs; or participate in the Special Supplemental Food Program for Women, Infants, and Children (WIC) or the Commodity Supplemental Food Programs; or participate in a state perinatal program. Few providers exist in Hawaii with some of these funding sources. For those not enlisted, DHS and DOH could together determine a full inventory of potential providers (including DOH-funded clinics) as is currently underway for WIC providers on neighbor islands.

Assessment of the Options

In assessing the eligibility and enrollment options for Hawaii, we examined three issues:

- . Impact of the expansions on the uninsured population in Hawaii.
- . Potential cost and health advantages in using Medicaid instead of SHIP to cover the eligible population.
- . Other cost issues.

This section discusses each of these issues in turn.

Impact of the expansions on the uninsured population in Hawaii. Medicaid eligibility expansion would likely enhance access to health care and improve health outcomes for the newly covered uninsured. The targeted nature of the expansions would also allow the State to cover some of the neediest of the working poor.

Expanded coverage for the working poor. Expansion of Medicaid eligibility to include the two options presented in this chapter would cover an estimated 7 to 10 percent of the low-income uninsured population in Hawaii. The percentage would be higher if the new options are combined

cost trade-offs between Medicaid and SHIP are tenuous at best. Because there has been no comprehensive household survey of the uninsured in Hawaii, there are not data that would allow DOH to project caseload characteristics and per capita costs for the gap group population. SHIP planners expect to design eligibility and benefits for the program very conservatively (e.g., waiting periods for persons with pre-existing conditions) until there is enough actual operational experience to determine with more certainty how much can be accomplished within the limited state appropriation.

Potential cost savings. Because DOH estimated SHIP costs are very tentative at this point, we have calculated *potential savings* to the State based on a series of assumptions on per capita SHIP costs. These potential savings are displayed in Exhibit 3.7 DOH has established tentatively an average state SHIP subsidy of \$500 per beneficiary per year (excluding beneficiary cost sharing). Because this subsidy is likely to be lower for children and higher for adults, we have varied the per capita assumption in the second column of Exhibit 3.7. The Medicaid per capitas are based on actual experience for current Medicaid enrollees with similar age characteristics. These were the Medicaid per capita amounts used in our estimates.

Exhibit 3.7 shows potential savings to the state of \$0.5 to \$1.6 million if Medicaid is used to cover the two new groups rather than SHIP. For the children up to poverty, savings could range from \$102,000 to \$702,000, and for the Medically Needy, savings could range from \$430,000 to \$900,000. The two Medicaid expansions would become more expensive to the State only if SHIP per capita expenses for these persons are lower than an average of about \$300. (These savings assume, of course, that any person who enrolls for Medicaid would have enrolled in SHIP in the absence of Medicaid eligibility. Depending on how SHIP is designed, this may not always be the case. Medicaid expansions are open-ended entitlements, whereas SHIP enrollment is likely to be limited by screening and underwriting provisions and/or budget limitations.)

Greater health benefits. Equally important, Medicaid would cover a broader range of services for these persons than would SHIP. The Hawaii Medicaid program includes a broad array of inpatient and outpatient services, generally exceeding the coverage of most standard insurance plans. SHIP benefits, on the other hand, will include only primary and preventive care, and limited inpatient care. While SHIP benefits have not been fully determined, the draft administrative rules propose exclusion of extended inpatient hospital care and most prescription and non-prescription drugs. Furthermore, SHIP imposes strict coverage limitations on persons with pre-existing medical conditions. A twelve-month or twenty-four-month waiting period may be required before SHIP will provide benefits for services or supplies provided for certain pre-existing medical conditions such as arthritis and kidney disease. Medicaid does not restrict coverage on the basis of health status.

Exhibit 3.7

**Estimated Savings in State Dollars by Use of
Medicaid Expansions Versus SHIP Assuming Varying Per Capita Costs for SHIP**

Medicaid Eligibility Option	Estimated Medicaid Enrollees*		State Costs (FY 1990-91)			State Costs (FY 1990-91)		Estimated Savings if State Uses Medicaid
			SHIP**	Medicaid***		SHIP	Medicaid	
Children, 4-8 Up to Poverty	3,000	x	\$300	\$265.90	=	\$ 900,000	\$ 797,700	\$ 102,300
			400	265.90	=	1,200,000	797,700	402,300
			500	265.90	=	1,500,000	797,700	702,300
Medically Needy @ 133% of AFDC Payment Standard	2,350	x	\$500	\$317.11	=	\$1,175,000	\$ 745,200	\$ 429,800
			600	317.11	=	1,410,000	745,200	664,800
			700	317.11	=	1,645,000	745,200	899,800
Totals for Combined Expansion	5,350	x	\$400	\$296.97	=	\$2,140,000	\$1,588,800	\$ 551,200
			500	296.97	=	2,675,000	1,588,800	1,086,200
			600	296.97	=	3,210,000	1,588,800	1,621,200

* Enrolled at some point during the year. See Exhibit 3.4 and Appendix C for estimating methodologies.

** SHIP per capita costs are currently unknown. DOH has assumed a state subsidy of \$500 per capita. This chart shows variations in this amount to illustrate possible differences created by target population. Thus lower amounts are illustrated for children, and higher amounts are illustrated for groups that will include adults.

*** Includes estimated DHS administrative costs. See Exhibit 3.4 and Appendix C for estimating methodologies.

Other cost considerations. In assessing the likely fiscal impact of Medicaid expansion on the state, at least three additional cost issues should be considered.

AFDC savings through reduction in the work disincentive. Elevation of income eligibility standards for Medicaid is likely to facilitate the transition from welfare to self-sufficiency for many current AFDC recipients. This, in turn, may create AFDC cost savings for the state. This is because the new income levels will help reduce the work disincentive associated with the loss of cash assistance.

One of the long-recognized problems in the AFDC welfare program is that recipients may be reluctant to take employment that will result in the loss of Medicaid benefits. The State's Work Transition Demonstration Project is designed to reduce this work disincentive by allowing AFDC beneficiaries who earn their way off cash assistance to retain medical benefits for a year. A similar provision is required by the U.S. Family Support Act (Welfare Reform), and will be implemented in Hawaii in April 1990.

The new income standards proposed in this chapter are also likely to support the transition from welfare to work. Currently an AFDC family of four earning more than about \$4.75 an hour will lose AFDC, and will eventually lose Medicaid after the relevant extensions have expired. With the new income standards, however, Medicaid coverage could continue indefinitely at wage levels of up to \$6.30 an hour (Medically Needy Standard) and \$7.35 an hour (poverty level standard).²⁷ For families concerned about medical care costs, the availability of Medicaid at these wage levels could figure prominently in their decision to actively seek and obtain a job. Thus there may be some savings to the state in AFDC costs.

Substitution of Medicaid for employer-based insurance. Some newly Medicaid eligible persons may drop employer-based insurance coverage, creating a shift in costs from private employers and employees to the State. Our CPS data base is too small, even with the pooled years, to estimate the potential for this substitution of coverage in Hawaii. An analysis of national CPS states, however, indicates that about one-third of persons who would become eligible for Medicaid under the nationwide poverty level income standard currently have employer-based coverage. Another 14 percent have non-group insurance plans that they have purchased out-of-pocket. In Hawaii, the number of newly eligible persons with an employer-based plan may be higher because of the Prepaid Health Care Act.

Only some persons currently insured through an employer-based plan, however, are likely to drop their coverage to sign up for Medicaid. For the employee, the employer will be covering 50 percent or more of the costs under provisions of the Prepaid Health Care Act, minimizing the financial advantage of switching to Medicaid.

Some employees, however, will be paying full cost for coverage for their dependents in addition to part of their own coverage. Clearly, it will be to the financial advantage of these employees to drop such coverage and move their dependents onto Medicaid under either the Medically Needy or young children provisions. Likewise, employees who are purchasing non-group plans out-of-pocket will be better off using Medicaid. Even some of these employees, however, may be reluctant to shift to Medicaid because of the perceived stigma associated with Medicaid, possible disruption in coverage as Medicaid eligibility changes, or the inconvenience of having different forms of coverage for different family members.

We have no way of predicting employees' behavior once they are faced with the choice of free insurance. Nor can we estimate the potential for substitution of coverage because of limitations in the CPS data base. Some shift in coverage, however, may be desirable. A family with a monthly income of \$700 to \$800 can hardly afford to spend \$100 or more on a non-group plan, and yet national data show that many do just that. At these low income levels, a state policy of accepting some substitution of Medicaid for private health expenditures may be a desirable way of helping families become self-supporting. This is especially important for families who are making the transition from welfare to employment, and for whom subsidized health care can make a significant difference in their ability to live on below-poverty wages.

Risk of unexpected Medicaid cost increases. Medicaid expansions run the risk of contributing to unexpected cost increases in Medicaid. Concern about containing Medicaid costs has been high in Hawaii, and some observers are understandably apprehensive about the potential for fueling cost increases in a program that has an unpredictable history of inflation. The population groups to be covered by these expansions have not, however, been the source of high expenditures, as shown in Exhibit 3.8. For example, while children account for 41 percent of all Medicaid recipients, they account for less than 13 percent of program reimbursements. Non-aged adults also account for a relatively small share of program costs. Much greater Medicaid expenses come from populations that will generally *not* be covered by the expansions: the aged, blind, and disabled.

Similarly, the children and non-aged adults to be covered by the expansions have not created inordinate cost increases in recent years. Exhibit 3.9 shows a per capita cost increase of 6.8 percent annually for AFDC children and 2.2 percent for AFDC adults between 1984 and 1988. Both figures are lower than national increases, and neither is out-of-line with the statewide average per capita increase of 6.1 percent.

This is not to say that the inflation issue should be ignored. Cost increases are of concern for Medicaid as they are for any other state program, and the State should continue to monitor

per capita costs carefully and ensure the use of adequate program cost controls for the entire Medicaid population, including the new eligibility groups.

Coordination Issues for SHIP and Medicaid

If the State is to optimize use of new Medicaid options as a way of caring for the uninsured, there are a number of coordination issues between SHIP and Medicaid that need to be addressed. Ideally, the two programs should be well coordinated so as to: (a) maximize federal dollars by ensuring that Medicaid is the preferred source of coverage and primary payer; (b) allow continuity of health care coverage for gap group members; and (c) encourage continuing access to Medicaid health care providers as well as new SHIP providers.

Several specific issues need to be examined as SHIP is further developed:

- . *Extent to which there will be a coordinated eligibility process that will allow for efficient assessment of program eligibility and facilitate enrollment shifts between the two programs.* Recipients will need to understand when and why their status is changing, and what the implications are for benefit coverage and cost-sharing. This is also important for families who will have varying coverage for different members, such as Medicaid coverage for young children and SHIP coverage for older children and parents. Coordination of enrollment could be accomplished through dual eligibility workers who are trained to register applicants in either SHIP or Medicaid. The SHIP function could be combined with the out-stationed Medicaid-only function described earlier, thereby allowing the working poor to use a *single location* and deal with a *single worker* to establish eligibility, with Medicaid as “priority” coverage. Changes in status between the two programs could also be handled by this worker.
- . *Extent to which the eligibility process for the two programs is accessible and straightforward.* SHIP and Medicaid-only enrollment could be made available in DOH clinics and other health care settings as a way of reaching a population who may otherwise be unlikely to consider public assistance or make use of a DHS applications unit. This would include “presumptively determined” maternity patients who are failing to register with DHS. Both SHIP and Medicaid could be presented and discussed as medical insurance programs rather than “welfare,” as a way of avoiding stigmatization. If possible, the two programs could even make use of similar enrollment forms and identification cards to reduce the distinctions between two programs that might otherwise appear quite similar to users except for the difference in benefits.
- . *Open enrollment arrangements for persons who lose Medicaid coverage, an arrangement that has been proposed in preliminary SHIP plans.*
- . *What process will be used for changing enrollment as eligibility status changes.* Many pregnant women, for example, will lose Medicaid coverage as 60 days of postpartum care end.

Extent to which current Medicaid dollars “stay in the system,” especially in the case of Medicaid spend down. One of the potential drawbacks of SHIP is that it will cover some persons who incur large medical bills and, in the absence of SHIP, would have “spent down.” If SHIP covers only limited hospital benefits (as has been proposed), hospitals that were formerly reimbursed for these “spend down” patients will no longer receive Medicaid funds and may see an increase in uncompensated care. To the extent SHIP does cover hospital care, the state program will be picking up hospital costs at full state expense rather than with the 54 percent federal match available through Medicaid.

Level of provider reimbursement. Unless rates are set at a fair and equitable level, there could be disruption in the current willingness of providers to see Medicaid patients. If SHIP reimbursement for physicians, for example, is set significantly higher than payments for Medicaid, access may become more limited for Medicaid patients.

Recommendations

On balance, it is our conclusion that Hawaii should implement both the Medicaid expansion options discussed in this chapter as well as related efforts to enhance enrollment of currently eligible populations. We also recommend that the State take steps to ensure that there is adequate coordination between the Medicaid expansions and SHIP. Depending on final SHIP design, these recommendations may result in a net increase in costs to the State, but we think the cost is worth the investment because of the additional uninsured who would have coverage and improved access to health care. Regardless of whether the State chooses to expand Medicaid eligibility and enrollment, however, we strongly urge that efforts be made to ensure adequate coordination between SHIP and the current Medicaid program.

We have four specific recommendations.

1. Expand Eligibility to Include All Children Age Four to Eight Up To the Poverty Level.

This option will help cover an important gap group--dependents of low wage workers--and it will help reduce the number of low-income uninsured in the State. It is also likely to be a more cost-effective way of covering selected gap group populations than the SHIP program by drawing on federal dollars to pay more than one-half of total costs.

2. Raise the Medicaid Income Eligibility Standard to the Maximum Allowed Under Federal Law Where It Would Not Incur Additional Welfare Expenditures.

Currently set at the AFDC Payment Standard, this threshold should be raised to 133-1/3 percent of the Payment Standard for all family sizes. This will cover another portion of the low-income uninsured, particularly those with incomes slightly higher than the welfare standard but still too low to make health insurance affordable. This option is also likely to be a more cost-effective form of coverage than SHIP.

3. Undertake Efforts to Enhance Enrollment in Existing and Future Medicaid-only Eligibility Categories.

Aggressive enrollment efforts can help Hawaii reduce the number of uninsured in the State, and help ensure adequate and timely access for low-income populations. This is particularly important for such target groups as pregnant women, for whom postponement of primary health care increases the chances of low birthweight and the need for expensive hospital care. Moreover, Medicaid coverage at income levels higher than current welfare levels can help the near-poor with the transition from welfare dependency to self-sufficiency.

As discussed earlier, efforts to enhance enrollment should include:

- . Development of a "short form" for Medicaid-only eligibles.
- . Placement of out-stationed enrollment workers in DOH clinics and other settings likely to be serving this population.
- . Continued efforts to recruit providers certified to determine "presumptive" eligibility.

This three-pronged strategy can be financed through a number of possible sources. Some funds will come to the state in the form of federal administrative match. Additional funds could be built into the DHS budget, or a cost-sharing arrangement could be made whereby DOH and/or private clinics likely to benefit from new federal dollars could allocate some funds to help pay for out-stationed workers. Cost-sharing arrangements also could be made with SHIP by combining the Medicaid and SHIP enrollment function (as discussed under the next recommendation). It should be noted in this regard that there will be initial *implementation* costs as well as ongoing support costs for new functions. Changes in the application form, for example, will trigger the need for changes in the DHS computerized eligibility system as well.

4. Ensure that SHIP is Well Coordinated With Medicaid.

As SHIP is further defined, it is critical that the two programs be well coordinated so as to:

- . Maximize federal dollars by ensuring that Medicaid is the preferred source of coverage and primary payer.
- . Allow continuity of health care coverage for gap group members.
- . Encourage continuing access to Medicaid health care providers as well as new SHIP providers.

To accomplish this, DHS and DOH need to coordinate closely to develop:

- . A unified or coordinated eligibility process that will allow for efficient assessment of program eligibility and facilitate enrollment shifts between the two programs. This could be accomplished through dual eligibility workers who are trained to register applicants in either SHIP or Medicaid, as discussed earlier.
- . An accessible and straightforward eligibility process for the two programs. As discussed earlier, SHIP and Medicaid-only enrollment could be made available in DOH clinics and other health care settings as a way of reaching a population who may otherwise be unlikely to consider public assistance or make use of a DHS applications unit.
- . Open enrollment arrangements for persons who lose Medicaid coverage, an arrangement that has been proposed in preliminary SHIP plans.
- . A process for changing enrollment as eligibility status changes.
- . Mechanisms for ensuring use of Medicaid dollars whenever applicable, especially in the case of Medicaid spend down as discussed earlier.
- . Fair and equitable provider reimbursement that will avoid disruption in the current willingness of providers to see Medicaid patients.

In summary, we recommend that Hawaii take full advantage of opportunities available to the State to use Medicaid federal dollars in the coverage of gap group members. We also strongly recommend that the State ensure effective coordination between SHIP and Medicaid in the continuing efforts to offer broad health care coverage for its citizens.

Chapter 4

ADMINISTRATIVE ASSESSMENT

Introduction

This chapter presents our findings on the administrative capacity of the Hawaii Medicaid program to maximize federal revenue for the state. Our study was designed to assess the ability of the Department of Human Services (DHS) to identify, assess, and implement Medicaid options to achieve expanded federal dollars for the financing of broader state policy objectives in the most cost-effective manner. In particular, we examined DHS's ability to obtain Medicaid reimbursement for current services funded with state dollars, ensure effective use of Medicaid in state efforts to cover the uninsured, and respond to ongoing federal changes in eligibility and benefit options.

The original charge for this study specified an administrative assessment of the Medicaid program within DHS. However, we chose also to examine the Department of Health's (DOH's) administrative structure as well as the potential for both departments to collaborate effectively in efforts to maximize federal dollars.

We found that both agencies need to further develop mechanisms that will allow them to work individually and collaboratively to identify and pursue opportunities for federal reimbursement. Some collaboration and planning in this area is already evident in both agencies. More is needed, however. These current efforts form an important foundation for what needs to be a more concerted interagency initiative to maximize federal Medicaid dollars in the health planning process.

In addition, we found that the need for coordination between the two Departments extends beyond the specific use of maximizing federal Medicaid dollars. The state's interest in providing coordinated and cost-effective health services to low income populations applies to both DHS and DOH. Collaboration between the two departments is essential to this goal. Thus we have encouraged collaborative action not just on Medicaid eligibility, but also on the State Health Insurance Program (SHIP) and other state endeavors aimed at ensuring health care for the medically indigent in the state of Hawaii.

This chapter recommends the following:

- . Both DHS and DOH should be directed to establish an internal coordinating body for addressing Medicaid issues in a consistent, coordinated manner.

- . An Interagency Task Force should be created to effect interdepartmental communication and coordination on efforts to expand federal Medicaid dollars and other state health initiatives involving the two departments.
- . Both departments need to make clear on a department-wide basis the State's desire that input be sought from all parties interested in the Medicaid program, and both departments need to establish a focal point and clear channels for input.
- . DHS should be directed to make timely assessments of new Medicaid eligibility and financing options as they become available, recommending to the Legislature whether they should be adopted or not.
- . Each department should establish information systems that will provide necessary data for effective assessments, monitoring, and evaluation of specific Medicaid options, and the overall extent of Medicaid coverage in the state of Hawaii.

The remainder of this chapter begins with a brief overview of DOH and DHS. It reviews initiatives recently undertaken by both agencies to help maximize federal dollars. We then discuss the need for better mechanisms and processes within the two agencies to encourage collaboration and maximization of federal dollars. The chapter closes with recommendations.

Overview of Relevant Agencies

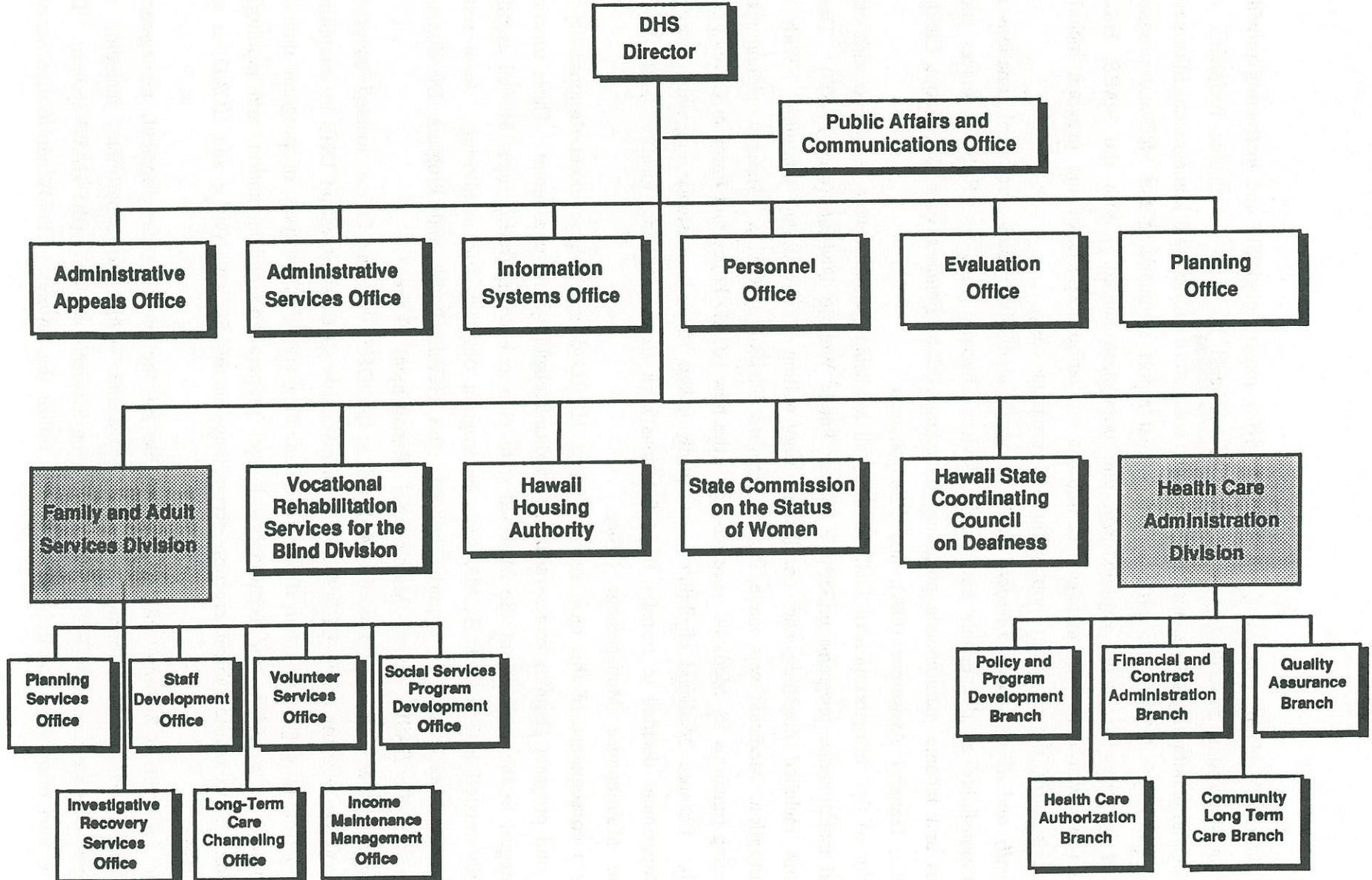
Exhibit 4.1 shows the overall organizational structure of the Department of Human Services (DHS).

Department of Human Services (DHS). The Department of Human Services (DHS) is an umbrella agency for the State's programs of human services, vocational rehabilitation, housing, economic assistance, and medical assistance. Responsibility for each of the major program areas rests at the division level, as shown in Exhibit 4.1. Medicaid functions occur in two of these divisions: the Health Care Administration Division, and the Family and Adult Services Division. DHS also has a series of support offices under the director that deal with Medicaid issues.

Health Care Administration Division (HCAD). The Health Care Administration Division (HCAD) has primary responsibility for Medicaid. HCAD oversees all aspects of Medicaid policy and administration except eligibility, which is handled by the Family and Adult Services Division. HCAD responsibilities include maintaining and updating the Medicaid state plan, ensuring compliance of administrative rules with federal and state law; negotiating payment rates and service contracts with providers; conducting quality assurance reviews; conducting prior authorization reviews; and developing waivers for and overseeing community long-term care services.

HCAD is also ultimately responsible for the oversight and coordination of the activities of the State's Medicaid fiscal intermediary, the Hawaii Medical Service Association (HMSA). HMSA's

DEPARTMENT OF HUMAN SERVICES



major duties are claims processing (including verifying patient eligibility and instructing providers on claim submission procedures), distribution of Medicaid ID cards to eligible recipients, and updating and maintaining subsystems and data in the computerized Medicaid Management Information System (MMIS). HMSA also produces an annual report summarizing the Medicaid program's activities in terms of claims, expenditures, and population served. With the MMIS, HMSA compiles program data into management reports on various aspects of the program including characteristics of the recipient population and program costs.

Family and Adult Services Division (FASD). Medicaid eligibility and enrollment functions are the responsibility of the Family and Adult Services Division (FASD). FASD oversees social services and income maintenance programs, including Aid to Families with Dependent Children (AFDC), General Assistance (GA), and Food Stamps.

Prior to the reorganization of DHS in 1986, all Medicaid functions were combined with other income maintenance programs under the former Public Welfare Division (now FASD). These functions included eligibility and enrollment, rule writing, and program planning. With the reorganization, Medicaid was made into a separate Division (HCAD). Initially, planning and rulewriting functions for Medicaid were moved to the new HCAD Policy and Program Development Branch. Because Medicaid eligibility is so closely linked to cash assistance eligibility, however, the Department decided to transfer these functions back to their original location in the FASD Income Maintenance Management Office.

As a consequence of this most recent change, HCAD does not have direct responsibility for policy and program planning issues regarding Medicaid eligibility and enrollment. These functions are integral to the updating of the Medicaid state plan and administrative rules, as well as other eligibility related activities of HCAD, such as program outreach and monitoring. As a result, considerable coordination is required between the HCAD Policy and Program Development Branch and the FASD Income Maintenance Management Office.

Support offices. Also involved in Medicaid is the DHS Planning Office, located under the Office of the Director. The DHS Planning Office assists all divisions within DHS in establishing short- and long-range goals and objectives; conducting statistical analyses of program data for federal and state review; and coordinating budget preparation, implementation, and monitoring activities. Thus, considerable interaction occurs between this Planning Office and HCAD, as well as HMSA.

The Information Systems Office is responsible for the planning, development, management, and maintenance of all information processing systems within the department, including the computerized system used by FASD for determining Medicaid eligibility (the HAWI system). This office is also responsible for training persons to utilize the systems. The Administrative Services

Office and the Evaluation Office offer additional support services to HCAD by providing accounting and financial management functions and implementing the quality control review system required by the federal government for Medicaid, respectively.

Department of Health (DOH). The Department of Health (DOH) is responsible for a range of public health, mental health, and acute care services in Hawaii. DOH also underwent a major reorganization early in 1989. This restructuring involved the creation of six new organizational bodies called Administrations, each under the direction of a Deputy Director. Within each Administration, there is a cluster of program offices and divisions, as shown in Exhibit 4.2 (See also Exhibit 2.1 for DOH services that are potentially Medicaid eligible).

Planning for the new State Health Insurance Program (SHIP) and recent efforts to increase Medicaid reimbursement for DOH programs are coordinated by the Deputy Director of Health Resources. This Deputy also oversees two divisions and three program offices under the Health Resources Administration (Exhibit 4.2). These include the Office of Planning, Policy and Program Development, which is responsible in part for planning studies and needs assessments for program development, and for coordinating health policy related activities, such as the department's legislative efforts and relations with the federal government. The Office is also charged with developing new programs and funding sources for DOH programs.

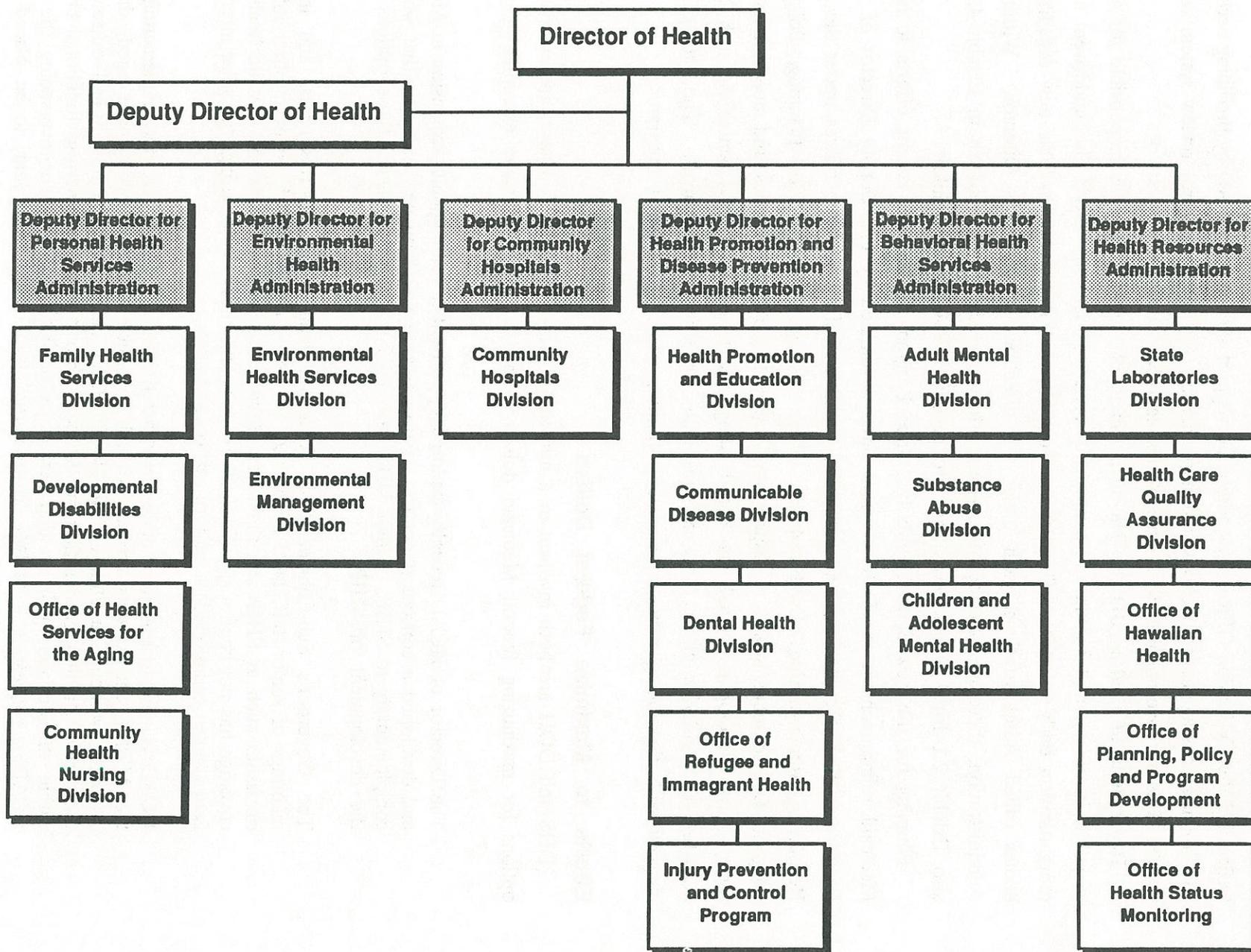
Efforts to Maximize Federal Dollars

DHS and DOH are both involved in a number of efforts to identify, assess, and/or implement options for maximizing federal Medicaid dollars. The following are some examples.

- . The Director of HCAD recently explored opportunities for eligibility expansion in Medicaid and developed a concept paper for discussions with DOH on new coverage that would be complementary to SHIP. Senior DHS and DOH staff have discussed these options during the development of SHIP.
- . The Governor's Sub-Cabinet Task Force on Human Services/Resources, and informal meetings of senior staff, have been used by agency directors to keep each other informed on issues such as SHIP and the recent Medicaid eligibility expansions. While health care coverage has not been a specific Task Force agenda item, the meetings on other interagency issues have established a pattern of collaboration.
- . HCAD is moving toward a more coordinated internal approach to the implementation of the MOMI amendments (recent federal amendments which made more aged, disabled, pregnant women and children eligible for Medicaid). Implementation and outreach for these new eligibility groups thus far has been spread among the various functional branches within the division, with no one person or formal mechanism for overseeing the effort. HCAD is requesting a MOMI "coordinator" position for next year, to be placed within

DEPARTMENT OF HEALTH ORGANIZATION CHART

100



the Policy and Program Development Branch. HCAD is also involved in efforts to recruit presumptive eligibility providers and plan additional outreach initiatives.

- . HCAD is also requesting a new position to coordinate implementation of the new federal requirement that Medicaid be extended for 12 months after a family loses cash assistance--known as the JOBS mandate.
- . DOH has formed a task force, which began meeting in the fall of 1989, to investigate opportunities for capturing federal Medicaid dollars in DOH programs.
- . Several DOH divisions are individually pursuing federal Medicaid dollars. The Mental Health Division is exploring benefit and billing opportunities; the Developmentally Disabled Branch has used a consultant to identify reimbursement opportunities; and the Family and Health Services Division was involved extensively in development of the MOMI initiative.

These efforts reflect a growing recognition and willingness by the leadership in both agencies to take action on maximizing federal dollars and to collaborate in doing so. The actions also create an important foundation for further steps we believe are necessary for implementing the recommendations outlined in previous chapters. Both DOH and DHS have begun to take specific steps to capture federal dollars. They can now build on this experience to ensure optimal use of federal dollars in state health policy on an ongoing basis.

Ongoing Capacity to Respond to Opportunities

Despite a clear willingness to pursue ways to maximize federal Medicaid revenue, DHS and DOH do not have in place processes and mechanisms needed to implement effectively the recommendations in this report and respond to future opportunities.

This situation in Hawaii is not unique, but partially reflects the new direction of the federal Medicaid program. The need and demand for this capacity has only developed in recent years. State Medicaid programs nationwide are shifting from an exclusive concern with cost containment to a broader focus on state and federal spending within the context of state health policy and fiscal goals. Access to health care for the uninsured, for example, has become a predominant issue in many states. This has led state Medicaid agencies and health departments to reexamine eligibility policies and the use of state-only dollars to finance programs for persons who are potentially Medicaid eligible.

Whereas DHS has in the past been concerned primarily with payment mechanisms and budget controls according to legislative and executive direction, the Legislature and the current state Administration are beginning to address a broader issue: How can state dollars be used most effectively and efficiently, given the overall health policy goals of the state? Within this context,

the concern is not *only* with cost containment initiatives, but also with the strategic use of federal dollars as judicious fiscal policy.

If the goal is not only to maximize federal dollars, but more fundamentally, to ensure a rational and cost-effective system of publicly financed health care within the state of Hawaii, then effective coordination between DHS (especially HCAD) and DOH is critical. They can no longer view themselves as having distinct and isolated missions. Both are involved in ensuring health care for disadvantaged populations in Hawaii. Thus they need to work together closely for optimal use of state dollars, as well as maximization of federal dollars. This need for coordination is especially critical in an era of constrained resources.

Our conclusion that these agencies are not well prepared for this emerging role is based on four general problems:

- . Lack of a focal point for coordination of many Medicaid issues within DHS.
- . Insufficient central planning capacity for Medicaid opportunities within DOH.
- . Insufficient coordination between the two departments.
- . Problems in communication with outside parties interested in Medicaid.

Lack of focal point for coordination within DHS. There is no single organizational unit within DHS that is clearly responsible for identifying opportunities and assessing and implementing options for maximizing federal revenue. Decentralization of these initiatives can be effective, provided the individual units are aggressive and there is an effective central focal point for a) planning and implementing proposals; b) resolving conflicts and developing consistent approaches to similar issues confronting each unit; and c) assuring lessons and analyses are shared. These three conditions have not been met.

Unfocused expansion efforts. While several branches within DHS have been involved in recent efforts to expand Medicaid, these efforts have often been diffuse and reactive. The MOMI initiative, for example, was analyzed outside of DHS by DOH staff and outside organizations. No single group within DHS took or was given responsibility to produce caseload or cost estimates for the expansions, or to help assess the initiative for the legislature. As a result, the DHS Planning Office only became involved in the MOMI estimating process at the very end of the budgeting cycle, at which time it had to work quickly and under some pressure to add administrative costs which had been overlooked in the original estimates.

The HCAD Policy and Program Development Branch now oversees implementation of MOMI, but implementation functions are spread among other divisions and branches and there is no single person (other than the Branch Chief) responsible for coordinating the efforts. As mentioned

above, HCAD is attempting to solve this problem by adding a coordinator position. In the meantime, however, there has been no designated focal point for planning and ensuring congruency among the range of MOMI-related activities, such as:

- . Establishing, implementing, and monitoring eligibility requirements, conducted by the Family and Adult Services Division.
- . Coordinating outreach and referral activities, including a MOMI hotline, also managed by the Family and Adult Services Division.
- . Tracking and reporting of eligibility and cost information, which would be the responsibility of the DHS Planning Office.
- . Updating, maintenance, and monitoring of the automated eligibility system (HAWI), carried out by the DHS Information Systems Office.
- . Training of eligibility unit staff on the use of the automated system as it applies to MOMI, including procedures for presumptive eligibility, also conducted by the DHS Information Systems Office.
- . Maintenance of the State Plan, administrative rules, and planning, carried out by the HCAD Policy and Program Development Branch.
- . Handling contract and payment issues, carried out by the HCAD Financial and Contract Administration Branch.

Because of this lack of central focus, the DHS response to opportunities for federal funding tends to be *reactive* in nature. Recent actions on MOMI, for example, have been in response to legislative resolutions and outside pressures from advocacy groups rather than *proactive* planning within the agency. DHS efforts to recruit presumptive eligibility providers came not from an internal analysis or recognition of MOMI underenrollment, but from a legislative resolution requiring action in this area.

Problems with use of data. The lack of central focus is also evident in the absence of program data analysis that can be used to monitor new initiatives. No unit within DHS, for example, has been monitoring MOMI enrollments over time, an important need for a program that was depending heavily on outreach efforts to effectively serve the target population. Nor have there been enrollment reports on the new elderly and disabled population with incomes up to the poverty level. To conduct our analysis, we found we had to construct enrollment trends for these new groups from individual monthly reports.

Similarly, we found that DHS has not produced program expenditure reports that can readily distinguish spending for federal/state Medicaid versus state-only Medicaid. The two programs are lumped together in financial and budget reports, obscuring the distinction between eligibility categories that yield a federal match versus those that are covered at full state expense.

This is not to say these data are unavailable. Efforts to design reports or extract pertinent data on such issues have apparently not been made, however. The federally designed Medicaid Management Information System (MMIS), for example, is a sophisticated financial data system operated by HMSA. The MMIS produces many management reports required by the federal government, few of which are useful in their current format for planning and monitoring purposes within DHS. Relevant reports could be extracted regularly from the MMIS on such issues as federal versus state expenditures, but there has been no systematic effort to do so within DHS. Consequently, the information was unavailable for this report, and would have been expensive to develop on a customized basis.

DHS also has an internal eligibility data base with detailed monthly information on program participants by eligibility category. The data base has not been set up, however, to produce regular reports on enrollment trends by various categories, information that will become increasingly important as the department continues outreach efforts for Medicaid-only groups.

Insufficient central planning capacity for Medicaid opportunities within DOH. DOH has little centralized planning capacity for analyzing opportunities for Medicaid coverage or other issues requiring coordination with DHS. As mentioned earlier, the Deputy Director for Health Resources Administration chairs a new Medicaid Task Force of division and branch chiefs. There are no staff positions delegated to assist with the work of the Task Force, however, and the Deputy Director himself already carries substantial commitments for development of SHIP and line management of the divisions and offices within the Health Resources Administration.

The Office of Planning, Policy, and Program Development could potentially play a coordinating role, but staffing has been minimal in this office since the DOH reorganization. Of the five designated planning positions, only two were filled by the end of 1989. Moreover, these positions were developed for ongoing department functional planning rather than the broader, strategic planning required for enhanced Medicaid reimbursement and ongoing coordination with DHS. These roles could change, of course, but the office is currently involved with routine planning and legislative relations rather than the Medicaid reimbursement issue or other efforts to ensure coordinated health policies by the two departments.

There is also a lack of centralized planning data in DOH needed to pursue Medicaid options. In many DOH divisions there were no data mechanisms that would allow us to determine service utilization by specific populations, per capita costs, health insurance status of recipients, or in

some cases, the income status of recipients. In part this is because many services within DOH, as with many other state health departments, are available to the general population. Thus there are often no means tests, and few reasons to collect individual encounter data from the patients. The need for this information is now clear, however, as DOH and the State of Hawaii look for ways to capture federal dollars and ensure efficient use of state dollars.

Insufficient coordination between the two departments. Collaboration between DHS and DOH has been evident at the executive levels, but has not always been translated into cooperative action among management level staff.

The eligibility and benefit recommendations made in this report require a high level of cooperation. Perhaps more importantly, DHS and DOH will continue to need an integrated approach to state health care programs as federal health care policies (including Medicaid) continue to change and as the state seeks cost effective approaches to ensuring health care for the poor and other Hawaii residents. As has become clear from both the SHIP effort and Medicaid expansion initiatives, neither department can afford to act in isolation. Executive staff in both DHS and DOH have become increasingly sensitive to this need for ongoing collaboration. The directors and some deputy director level staff have stepped up interaction (both formal and informal) around such initiatives as SHIP, MOMI, and efforts to obtain reimbursement for DOH services.

This cooperative stance at the senior levels has not been translated, however, into productive joint activities among management staff in the two agencies. In general, many staff in both agencies are not viewing cooperation as a valued function. There are few perceived rewards for collaboration, and there has been a history of tension between the two agencies.

The resulting lack of interaction is evident in a number of areas:

- . The MOMI initiatives, as mentioned earlier, were developed primarily by DOH, with little apparent consultation between the two agencies (although staff in both agencies report attempting to initiate such communication).
- . Involvement of DHS in the development of SHIP has been limited and sporadic. There was no active involvement of DHS staff, for example, in the Eligibility Subcommittee of the SHIP Advisory Council despite a range of critical issues regarding coordination of SHIP and Medicaid eligibility (see Chapter Three). DOH apparently did little to ensure participation and assistance from DHS in the subcommittee process, while DHS apparently choose to take a passive stance toward the eligibility issue.
- . Operations management staff within both agencies tend to be ill-informed about SHIP planning activities undertaken at the director and deputy director levels. We found that staff within DOH were largely unaware of the issues and proposals involved in the

development of SHIP despite the fact that their programs could be significantly affected by an expansion of insurance coverage in Hawaii. Similarly, we found that both relevant planning offices in DHS (HCAD's Policy and Program Development Branch and the DHS Planning Office) were unaware that the HCAD administrator had developed a concept paper--complete with cost and caseload estimates for certain Medicaid expansions--on the complementary role of Medicaid with SHIP.

We also found that DHS and DOH management staff that are involved in interagency issues are often not well informed about each other's programs. This is not unusual for state programs, and may not have been problematic in the past. Nor is it a reflection on the staff members themselves, who generally have not been expected to be familiar with outside programs. Now, however, such knowledge is essential. Efforts to obtain Medicaid dollars for DOH programs require a fundamental understanding of Medicaid eligibility, benefits, and reimbursement. Efforts by DHS to expand outreach to pregnant women requires an appreciation for prenatal health care needs and available services. Efforts by DOH to plan SHIP eligibility and enrollment procedures require knowledge of current procedures used for Medicaid.

Problems in communication with outside parties interested in Medicaid. DHS has few formal mechanisms for obtaining input from outside organizations which can assist with planning and implementation of new eligibility options.

There are a wide range of private and public organizations in Hawaii that can help with Medicaid initiatives, including health care providers, DOH programs, state committees and planning and advisory bodies, and advocates of low-income, disabled, and elderly populations. DHS has worked with these groups, but often on an intermittent ad hoc basis depending largely on how aggressively the groups pressed the department. In some cases there have been committees to help with particular planning issues, but even these may not always offer effective channels for input. Many DOH staff, for example, expressed frustration with their efforts to affect HCAD policy on EPSDT through a standing interagency committee.

There has been no clear message that outside input should be valued in DHS. The orientation of HCAD has been toward cost containment and the technicalities of eligibility more than planning for new federal dollars or Medicaid expansion initiatives. Yet outside groups can be and have been tremendously useful to HCAD. As the division continues to seek ways to enhance enrollment for the MOMI options, for example, it could draw on advice from health care providers who may have important insights on the health seeking behavior and income characteristics of potentially eligible patients.

The Medical Assistance Advisory Committee could potentially play an active advisory role to HCAD. Federal Medicaid regulations require that states establish a Medicaid Advisory Committee

to review and make recommendations on state Medicaid policies. The composition of the committee is required to have broad community representation, and include representatives of the health professions, beneficiary representatives, and members of consumer groups.

The Medical Assistance Advisory Committee in Hawaii, however, has neither the authority nor the sense of mission to play a proactive advisory role. Meetings of the group have been mainly limited to informational presentation on topics selected by HCAD staff, with no regular method of soliciting assistance from the members and no commitment or requirement to make use of such advice.

While this study was not initially designed to focus on DOH administration, it was apparent that few regular channels existed for communication between that agency and outside parties as well. An advisory committee and design subcommittee were formed for the development of SHIP, but their efforts have been specific to that program. Like DHS, DOH could benefit from ongoing input from groups that could help with Medicaid reimbursement and other future efforts to save costs and improve delivery of health care services.

Recommendations

In assessing mechanisms for helping DHS and DOH maximize federal Medicaid dollars, we considered seven broad options:

- . Establishment of internal planning and coordinating bodies within DHS and DOH.
- . Establishment of an interagency committee with ongoing responsibility for assessing and planning ways to maximize federal dollars for state health policy objectives.
- . Creation of additional DHS staff positions in existing offices as needs arise, as is now the case with HCAD seeking a MOMI Coordinator position.
- . Use of DOH/DHS interagency coordinating committees to address individual issues as they arise, such as the current EPSDT committee.
- . Transferring the Medicaid program to DOH as a way of ensuring better coordination with DOH programs.
- . Creation of a new planning agency or department outside of both DOH and DHS.
- . No action beyond current efforts.

The first two of these strategies was selected along with a number of supplementary recommendations. An overview of the other options and why they were rejected is offered in Appendix E. The remainder of this chapter presents our recommendations in detail.

Both DHS and DOH should be directed to establish an internal coordinating body for addressing Medicaid issues in a consistent, coordinated manner. Each of the departments needs a focal point for maximizing federal Medicaid dollars as recommended in Chapters Two and Three of this report. This coordinating role is also important for other Medicaid-related initiatives that will affect the mission and operations of varying divisions and branches within the departments. DHS, for example, will need to ensure consistent and coordinated policies regarding its relationship to SHIP, and the various eligibility and enrollment interactions between SHIP and the Medicaid program.

This recommendation may or may not require additional staffing within the two departments, depending on how much flexibility there is for reassigning existing staff or reallocating existing vacant positions. There does, however, need to be a commitment to the *function* of coordination within each department.

Department of Human Services (DHS). DHS has already started on this by seeking coordinator positions for MOMI and the JOBS mandate in the HCAD Policy and Program Development Branch. Because the need for coordination will involve more than just these two initiatives, however, we encourage the establishment of more permanent staffing with a broader policy focus.

The new function might be established in the HCAD Policy and Program Development Branch, although this may be unworkable because of the split in Medicaid activities between HCAD and FASD. The new role could also be housed in the current DHS Planning Office, or it might be a new functional entity at the director's level.

The DHS coordinating entity would be charged with ensuring effective monitoring, assessment, and implementation of such issues as: new optional and mandatory Medicaid eligibility categories; outreach for existing Medicaid eligibility categories; other relevant changes in federal Medicaid policy affecting funding; out-stationing of Medicaid (and possibly SHIP) enrollment workers; Medicaid eligibility interactions with SHIP; and policy and state plan changes needed to assist with DOH efforts to obtain Medicaid payment.

Department of Health (DOH). DOH has also taken steps to coordinate Medicaid initiatives internally through the newly established Medicaid Task Force. The need for department-wide planning and monitoring will only grow, however, as divisions begin to identify and analyze options. Billing mechanisms, for example, should be developed not by individual divisions acting in isolation, but by a centralized planning staff working in concert with the various divisions.

This coordinating and policy-planning capacity might be lodged in the Office of Planning, Policy, and Program Development. Alternatively, it could be a separate unit under the director or the deputy director for Health Resources Administration.

An Interagency Task Force should be created to effect interdepartmental communication and coordination on efforts to expand federal Medicaid dollars and other state health initiatives involving the two departments. We view this as the best way to (a) encourage a new sense of mission in DHS and DOH; (b) ensure coordination between the two agencies and among key divisions within the agencies; and (c) ensure sustained attention and action on the range of areas where program development will be critical, especially eligibility and enrollment expansions, benefit and billing changes within DOH, the implementation of SHIP, and consideration/assessment of new federal eligibility options or development of initiatives.

Specifically, the Task Force should be delegated to:

- . Identify the current communication problems between the two departments and the lack of information on each other that currently exists, and establish a process for educating each other's staff and exchanging relevant information on an ongoing basis.
- . Identify the issues involved in assessing Medicaid options and the data needed to do it, and establish a process that provides sufficient data and examination of the concerns of both departments.
- . Examine the recommendations of this report and their implications for both departments, address the issues needing coordination between departments, and establish a detailed plan for mutual implementation.
- . Identify other state health policy issues requiring coordination between the two departments and develop a plan for interdepartmental collaboration.

The Task Force should be required to submit a formal annual report to the Governor, which in turn would be submitted to the Legislature. In the initial year, the report should detail progress made on each of the charges to the Task Force, as well as the detailed plan for mutual implementation and collaboration of the DHS and DOH on the recommendations in this report.

The Task Force should remain in place for as long as there continue to be interagency issues requiring coordination.

Both departments need to make clear on a department-wide basis the State's desire that they seek input from all parties interested in the Medicaid program, and to establish a focal point and clear channels for input. The mechanism for obtaining this input may vary depending on the particular initiative, target population, and technical issues raised by the initiative in questions.

For some issues, an advisory committee may be needed, while others might be handled through a series of public meetings, focus groups, or informal information sharing. Within DHS, the state could also consider redefining the mission, membership, and authority of the current Medical Care Advisory Board as a vehicle for this function.

Each Department should establish information systems that will provide necessary data for effective assessments, monitoring, and evaluation of specific Medicaid options, and the overall extent of Medicaid coverage in the State of Hawaii. For DHS, existing data systems need to be adapted to provide ongoing information and special reports on the effects of new benefits, eligibility and enrollment initiatives. This should include the capability to produce:

- . Monitoring of enrollment trends, including changes in demographic characteristics of populations covered.
- . Analysis of financial impact of new initiatives, including both state and federal dollars.
- . Analysis of financial trends for various population groups and service categories over time.
- . Evaluation of outreach and enrollment procedures for Medicaid-only populations.

For DOH, this should include systems to record and analyze service utilization by specific populations, per capita costs, health insurance status of recipients, and in some cases, the income status of recipients.

DHS should be directed to make timely assessments of new Medicaid eligibility and financing options as they become available, reporting to the Legislature on recommendations to adopt or not. DHS should monitor Medicaid developments at the federal level, and should produce for the Legislature analyses of new options, including:

- . caseload and cost estimates;
- . the potential for new federal dollars and state savings (if applicable); and
- . potential impact on access to health care for the medically indigent population.

DHS should also be directed to fully consider interagency coordination and the concerns of other interested parties in its assessment and planning of new Medicaid options, and to address these in any program it considers.

With these five recommendations in place, we feel Hawaii will be well equipped to maximize federal dollars in its health programs. We now turn to a strategic plan for implementation of these and the other recommendations in this report.

Chapter 5

STRATEGIC PLAN

This chapter summarizes our recommendations in the form of action steps and a timetable for implementation. This “strategic plan” is designed to help Hawaii put all three sets of recommendations from the previous three chapters into place over the next 6 to 24 months.

This chapter is organized into two sections:

- . Additional issues for study
- . Strategic plan action steps

Additional Issues for Study

Before presenting the Strategic Plan, it is important to note several critical issues outside the defined scope of work that were raised during the course of this study but which we felt the State should also examine. When combined with the specific action steps in the strategic plan, these additional efforts would contribute to a truly comprehensive effort to make optimal use of federal Medicaid dollars in pursuit of statewide health policy goals. The issues are:

- . **Cost-effectiveness of the Hawaii Medicaid program.** Strategies for tapping into new federal dollars represent only part of a much broader need for the State to ensure that both federal and state dollars in the Medicaid program are being used effectively. As the State takes actions to enhance federal funding, it should also ensure that the benefits and services added to the program are not contributing to unnecessary cost increases. We recommend that the State undertake a more comprehensive assessment of cost effectiveness within the Medicaid program, including such areas as payment systems and rates, the extent and effectiveness of managed care, the cost impact of community alternatives to institutionalization, prior authorization procedures, and utilization review.
- . **Efficiency and effectiveness of services provided in DOH clinics.** Additional Medicaid coverage for DOH clients should be combined with an assessment of the effectiveness of services provided to those clients. Extent of efficacy in clinic services became a particularly important question during the course of this study, i.e., do clinics have adequate volume and concentration of services to ensure cost effective care?
- . **Effectiveness of DOH program efforts to ensure client enrollment in Medicaid, i.e., do the DOH systems include assistance to clients in helping them determine their potential eligibility and getting them enrolled?**

- . **Effectiveness of EPSDT** (Early and Periodic Screening, Detection, and Treatment) for children. There were signs that both DHS and DOH could refine EPSDT as a comprehensive financing and delivery system for Medicaid-enrolled children, including development of more effective outreach.
- . **Statewide data needs on the uninsured.** Both this study and the SHIP effort have raised serious concerns about the inadequacy of reliable data in Hawaii on characteristics and health care needs of the uninsured. Our eligibility and enrollment recommendations were necessarily tenuous, not only because of uncertainty about the population itself, but also because there is so much unpredictability in the likely scope and impact of the SHIP effort. The State should consider undertaking a household survey to meet this need, which is likely to continue as the State struggles over the next several years with the issue of the uninsured. The State should also investigate the potential for better data systems associated with the Prepaid Health Care Act. Employers are required to report to the Department of Labor and Industrial Relations on their insurance offerings, but no comprehensive analysis of this potentially rich data base is available to assess the scope, impact, and effectiveness of the Act on the goal of ensuring coverage for working persons in Hawaii.
- . **Need for a comprehensive state health plan.** This study has highlighted the fragmented nature of the variety of approaches used by Hawaii (and other states) to ensure health care coverage for the poor. It is a “patchwork” system, including federal/state Medicaid for some populations, state-only Medicaid for others, and now SHIP for still others. At the same time, selected subsidized services are offered through DOH clinics and other community health centers. Overlaying all this is the Prepaid Health Care Act which is intended to encourage the workplace as the source of insurance coverage. These multiple approaches can create confusion among recipients, and result in unnecessary state expenditures through duplication and layers of administrative cost. Thus, it may be in the interest of the State to work toward integration of these approaches through a comprehensive planning process.

Strategic Plan Action Steps

We have divided the action steps in the strategic plan into immediate (0-6 months), short term (6-11 months), and long term (12-24 months) timeframes in each of the three areas of action: administrative changes, benefits and billing adjustments, and eligibility modifications. The expectation is that the state will begin planning and implementation of the options for enhanced benefits, billing, and eligibility simultaneously with arrangements for the administrative recommendations. While the administrative improvements will help Hawaii with ongoing efforts to maximize federal Medicaid dollars, there is no reason for either DOH or DHS to delay planning for the program improvements recommended in this report.

STRATEGIC PLAN FOR:
ADMINISTRATIVE CHANGES IN DHS AND DOH TO SUPPORT
MAXIMIZATION OF FEDERAL MEDICAID DOLLARS
(RECOMMENDATIONS FROM CHAPTER 4)

IMMEDIATE ACTION STEPS (0-5 MONTHS)

- Step 1: **Determine structure and staffing of new coordinating entities within DHS and DOH.** As discussed in Chapter 4, both departments need to establish an internal focal point for assessing, implementing, and monitoring the recommendations in this report. Executive staff in both departments need to determine:
- . where, organizationally, the focal point will be, including the level of authority and responsibility.
 - . staffing and other resource requirements, including a determination of whether new staff or positions are required, or whether current responsibilities can be reallocated.
 - . responsibilities and goals of those assigned coordinating functions.
- Step 2: **Assess capability of current data systems and develop a plan for expansion or modification.** DOH needs to determine what information will be needed to determine Medicaid eligibility and conduct billing in its programs. DHS will need to inventory current reporting systems and determine what changes are needed to monitor caseloads and costs as discussed in Chapter 4.
- Step 3: **Develop plans for formation of an interagency task force.** A working group of senior representatives from both DHS and DOH should develop a plan for the task force that would include its:
- . composition
 - . goals, responsibilities, and timelines
 - . staffing and other resource requirements
 - . governance structure and nature of reporting channels
- Step 4: **Submit budget and authority requests--to the extent needed--to the Legislature for implementing the:**
- . Coordination function in DHS
 - . Centralized planning function in DOH
 - . Interagency Task Force

Step 5: **Assess current channels for input from outside parties and modify or add to them as recommended in Chapter 4.** This should be done by both DOH and DHS.

SHORT-TERM ACTION STEPS (6-11 months)

Step 1: **Convene Interagency Task Force to:**

- . Identify communication needs between the two departments
- . Establish a process for educating each other's staff and exchanging relevant information on an ongoing basis.
- . Identify areas of cooperation needed to implement recommendations in this report and develop detailed plan for mutual implementation, including:
 - Goals and timelines
 - Assigned responsibilities

Step 2: **Implement data systems in DHS to monitor and assess initiatives to maximize federal dollars, including capability to monitor:**

- . enrollment trends
- . financial impacts (state and federal)
- . outreach efforts and enrollment procedures

Step 3: **Implement data systems in DOH that will allow for patient level information on service utilization, per capita costs, health insurance status, and income.** Implement other systems as needed for billing purposes.

Step 4: **Continue meetings of Interagency Task force to pursue steps outlined below for the major recommendations.**

LONG-TERM ACTION STEPS (12-24 months)

Step 1: **Plan and implement statewide data systems that will allow for better statewide health care planning, including, for example, a survey of the uninsured in Hawaii.** This planning could be coordinated by the Interagency Task Force. DHS and DOH would jointly develop the plan.

- Step 2: **Continue monitoring, planning, and assessing opportunities for federal Medicaid funding** as well as other cross-agency issues that may have an impact on state financing of health care. This would be a major responsibility of the two departments. Coordination could be established through the Task Force.
- Step 3: **Evaluate efforts to expand federal Medicaid funding and make optimal use of state health dollars**, a task that should be carried out by the two departments. Coordination could be established through the Task Force.
- Step 4: **Report to Legislature on progress and issues.** Both departments should report on success to date in implementing the above steps and capturing new federal dollars. The Interagency Task Force should also submit a formal report, detailing progress made on each of the areas in this report.

SHORT-TERM ACTION STEPS (6-11 months)

- Step 1: Develop system for identifying and allocating Health Department funds to be used in financing the state's share of the expanded market. Depending on the decision made in Step 2 above, the Legislature and DOH need to develop a method for using DOH funds to obtain the federal match. Otherwise, the two agencies and other agencies will handle in a not-necessarily in the state's Medicaid budget.
- Step 2: Develop final plans for service and funding options. DOH and DHS need to work jointly on the following:
- Analysis of actual DOH services costs resulting in Medicaid for schedules that are not include incentives for efficiency.

STRATEGIC PLAN FOR:
BENEFIT AND BILLING OPTIONS FOR
MAXIMIZING FEDERAL DOLLARS IN DOH PROGRAMS
(Recommendations from Chapter 2)

IMMEDIATE ACTION STEPS (0-5 months)

- Step 1: **Develop an action plan for development and implementation of DOH benefit and billing options.** This should be produced by senior level DOH staff in conjunction with the activities of the Task Force as outlined above. The action plan should include:
- . Establishment of goals and action steps for each of the recommendations in Chapter Two of this report, as well as other Medicaid opportunities subsequently identified.
 - . Assignment of division, branch, and individual responsibilities.
 - . Setting of timelines and target dates.
- Step 2: **Establish policy on funding for the State match and use of new federal revenues.** The Legislature needs to set policy on how the State match for Medicaid expansion will be funded and how new Medicaid revenues will be used. The new federal dollars could be used to enhance and expand DOH services and/or reduce state spending. The flow of Medicaid dollars through the State can be structured so that DOH receives none, some, or all of the federal match.

SHORT-TERM ACTION STEPS (6-11 months)

- Step 1: **Develop system for identifying and allocating Health Department funds to be used in financing the state's share of the required match.** Depending on the decisions made in Step 2, above, the Legislature and DOH need to develop a method for using DOH funds to obtain the federal match. Otherwise, the new service and billing options will result in a net increase in the state's Medicaid budget.
- Step 2: **Develop final plans for service and billing options.** DOH and DHS need to work jointly on the following:
- . Analysis of actual DOH service costs, resulting in Medicaid fee schedules that are fair but include incentives for efficiency.

- . Development of efficient billing procedures for each DOH Division, including plans for how billing will be handled for contract providers (e.g., DOH as “billing agent”).
- . Development of service definitions consistent with goal of minimizing Medicaid cost increases outside of DOH.
- . Development of provider qualifications or standards designed to limit reimbursement--to the extent possible--to DOH-funded providers.
- . Development of appropriate policies and procedures regarding DOH prior authorization of certain Medicaid services.

Step 3: **Prepare and submit required state Medicaid plan amendments to HCFA, and revise administrative rules.** This should be a joint DHS/DOH effort, with coordination possibly established through the Interagency Task Force. State plan changes would include:

- . Targeted case management service and reimbursement provisions;
- . Expansion of rehabilitative service category;
- . Broadening of licensed practitioner category.

Step 4: **Implement and monitor service and billing initiatives.** The central planning unit within DOH should coordinate implementation, with each division or branch taking the lead.

LONG-TERM ACTION STEPS (12-24 months)

Step 1: **Assess impact of service and billing options.** The DOH central planning staff should develop and implement an assessment plan for conducting:

- . An ongoing audit of program billing and enrollment procedures for each program.
- . An assessment of trends in the number and type of Medicaid cases covered.
- . A calculation of federal revenues generated, and the extent and nature of the resulting DOH enhancement or addition of services (if applicable).

Step 2: **Modify and expand Medicaid coverage for DOH clients as needed.** DOH should work with DHS to ensure continuing maximization of federal dollars. Coordination could be established through the Task Force.

STRATEGIC PLAN FOR:
ELIGIBILITY AND ENROLLMENT EXPANSIONS
(RECOMMENDATIONS FROM CHAPTER 3)

IMMEDIATE ACTION STEPS (0-5 months)

- Step 1: **Design action plan for implementation of eligibility and enrollment expansions and ongoing monitoring of future opportunities.** This plan should be developed by the new coordinating unit or function in DHS, in close consultation and coordination with DOH where appropriate. Coordination could be established through the Task Force. The plan should include:
- . Goals and action steps for each of the recommendations in Chapter Three of this report, as well as other Medicaid opportunities subsequently identified.
 - . Division, branch, and individual responsibilities.
 - . Timelines and target dates.
- Step 2: **Develop and submit budget requests for new eligibility and enrollment options.** To be prepared by DHS, these would include requests for
- . Funds and staffing needed for the Medically Needy and young children eligibility expansions.
 - . Funds and staffing needed for enrollment and outreach initiatives.
 - . Shared funding or staffing arrangements with DOH to conduct joint enrollment for SHIP and Medicaid.
- Step 3: **Develop coordination mechanisms between SHIP and Medicaid.** The DHS and DOH need to jointly decide how, if at all, joint enrollment will occur, and how benefits, payment rates, and eligibility transfers will be handled between the two program. Joint staffing and funding arrangements may be needed for the enrollment function, including any necessary interagency agreements. Coordination could be established through the Task Force.
- Step 4: **Continue enrollment outreach efforts.** DHS needs to continue, and perhaps enhance, current efforts to expand awareness of Medicaid-only eligibility categories and recruit presumptive eligibility providers.

SHORT-TERM ACTION STEPS (6-11 months)

Step 1: Implement new eligibility categories. Relevant offices in DHS will need to:

- . Modify the state plan and administrative rules.
- . Modify policies and procedures used by eligibility staff, including specific instructions and procedures on new eligibility categories.
- . Supplement or reallocate eligibility workers to cover new enrollees.
- . Update the computerized enrollment system.
- . Train eligibility workers.

Step 2: Implement efforts to enhance enrollment of Medicaid-only populations. DHS should work with DOH to:

- . Develop the short form for Medicaid-only applicants, integrate it into the computerized eligibility system, and implement use of the form.
- . Select sites for out-stationed eligibility workers, and add or reallocate staff positions for the new sites.
- . Implement computerized enrollment systems on the new sites, or design portable systems.
- . Train new eligibility staff in out-stationed positions.

NOTES

Chapter 1

1. Because there has been no recent household survey on this issue in Hawaii, the exact percentage of uninsured persons is uncertain. See Appendix D for a discussion of the various existing estimates. Percentages for other states are based on Lewin/ICF estimates from the Current Population Survey, 1987.
2. Hawaii, Department of Health, *The Medically Indigent in Hawaii, A Preliminary Report to the Legislature in Response to Senate Resolution 149-86, S.D. 1, 118, H.C.R. No. 232, HD1 and H.R. No. 388, HD1 Requesting the Department of Health to Continue to Study the Problem of Providing Care to Indigents in Hawaii*, Honolulu, 1988.

Chapter 2

1. At the conclusion of this study, the U.S. Congress made a significant change in required services. Effective April 1, 1990, state Medicaid programs will be required to provide Medicaid-enrolled children any federally allowable service that they are found to need as a result of a child health screening examination billed under the mandatory EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) benefit. 42 U.S.C. sec. 1396(d) (as amended by the Omnibus Budget Reconciliation Act of 1989, enacted November 21, 1989). Thus, reimbursement for DOH services to children will become mandatory.
2. Prior authorization takes place before the service is rendered; utilization review takes place after.
3. 42 C.F.R. sec. 440.230 (1988).
4. 42 C.F.R. Sec. 440.230 (1989).
5. 42 C.F.R. Sec. 440.240 (1989).
6. H.R.S. sec. 26H (1985).
7. H.R.S. sec. 321-11 (1985).
8. Information provided to project staff in telephone conversations with Charles Booth, Director of the Office of Payment Policy, Bureau of Policy Development, Health Care Financing Administration.
9. Such an agreement would be particularly useful for small providers who have never had to bill on a fee-for-service basis before.

10. "FFP Availability for Free Services," Bureau of Policy Development, Health Care Financing Administration, Department of Health and Human Services, Memorandum, July 11, 1989.
11. 42 C.F.R. sec. 440.90 (1988).
12. 42 C.F.R. sec. 440.130 (1988).
13. The program must be approved by approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent.
14. The program must be approved by the Council on Medical Education of the American Medical Association.
15. 42 C.F.R. sec. 440.110 (1988).
16. 42 C.F.R. sec. 440.60 (1988).

Chapter 3

1. Exhibits 3.2 and 3.4 are simplified representations of Medicaid eligibility. Income standards are net of allowable deductions including child care expenses, work related expenses, and certain work incentive disregards. Thus persons with gross incomes above the income thresholds shown may be eligible.
2. Exhibit 3.2 does not include a new eligibility group that was mandated by the federal government at the conclusion of this study. According to the federal Omnibus Reconciliation Act of 1989, Hawaii must cover all children up to age six with family incomes up to 133 percent of the poverty level. Hawaii is required to implement this group by April 1, 1990.
3. Through the Medicare Catastrophic Act of 1988, the federal government now mandates Medicaid coverage of Medicare premiums, copayments, and deductibles for persons under poverty (called "Qualified Medicare Beneficiaries"). This provision was retained despite the repeal of the majority of the Act in 1989. Although the poverty option in Hawaii largely covered this group already, additional elderly and disabled are eligible through the mandatory provision because it uses a higher asset limit than the optional poverty threshold.
4. Hawaii adopted the 100 percent threshold in January 1989, at which time it was still optional for the states. The Medicare Catastrophic Act of 1988 now requires that all states adopt a poverty threshold for pregnant women and infants by July 1, 1990. Also, at the conclusion of this study, Congress mandated coverage for pregnant women, infant, and children up to age six in families with incomes up to 133 percent of the poverty level.
5. Two income thresholds are used in determining AFDC eligibility (and hence Medicaid eligibility), only one of which is illustrated in Exhibit 3.2. First, The *Need Standard* is compared to a family's gross income as an initial eligibility screen. A family with a gross income higher than 185 percent of the Need Standard is disqualified for consideration. In

Hawaii, the Need Standard is set at 100 percent of the poverty level and increases with changes in the poverty threshold. If the family meets this first eligibility test, certain deductions and work incentive "disregards" are subtracted from their gross income. If the remaining figure is no more than the state *Payment Standard*, the family is eligible for AFDC and Medicaid. The Payment Standard in Hawaii now is set at 62.5 percent of the Need Standard. Prior to July 1988, the *Need Standard* in Hawaii was at the same level as the *Payment Standard* and both were lower than the current level. Only the *Payment Standard* is illustrated in Exhibit 3.1, although *both* new thresholds have contributed to expanded AFDC eligibility in Hawaii.

6. At the conclusion of this study, the U.S. Congress mandated coverage (as of April 1, 1990) of a new population group in the Omnibus Reconciliation Act of 1989: pregnant women and children up to age 6 with family incomes below 133 percent of poverty. Thus the optional group of below-poverty children analyzed for this report has become mandatory for children age 4 to 6.
7. At the conclusion of this study, the U.S. Congress mandated a new Medicaid Only category that must be covered by Hawaii by April 1, 1990: children up to age six with family incomes up to 133 percent of poverty.
8. Unpublished Lewin/ICF analysis of data from the Current Population Survey, U.S. Census Bureau, 1988.
9. Lou Harris, Inc., "Household Survey on Eligibility for New Medicaid Categories," conducted for the Florida Department of Health and Rehabilitation Services, 1986; Colorado Task Force on the Medically Indigent, "Colorado's Sick and Uninsured: We Can Do Better," January 1984.
10. Lewin/ICF analysis of Current Population Survey data (U.S. Census Bureau) for Hawaii, pooled for the years 1984, 1985, 1987, and 1988. See Appendix C for methodology.
11. Lewin and Associates, "Medicaid Eligibility Expansion Estimates for the State of New Mexico," prepared for the Medical Assistance Program, New Mexico Human Services Department and New Mexico Health Care Cost and Access Commission, January 22, 1986; National Governors' Association (NGA), *Reaching Women Who Need Prenatal Care*, Washington, D.C., 1988.
12. Caseload data from the Kalihi-Palama Clinic, Honolulu, January-September, 1989.
13. Unpublished Lewin/ICF analysis of data for the Current Population Survey, U.S. Census Bureau. "Health Care for the Medically Indigent in Pennsylvania," Analytic Report prepared for the Pennsylvania Health Care Cost Containment Council, June 1988; National Governor's Association (NGA), *Reaching Women Who Need Prenatal Care*, Washington, D.C., 1988.
14. NGA, 1988.
15. NGA, pp. 31-33.

16. The CPS-based estimates are higher than some other estimates of the uninsured in Hawaii. Appendix D provides an overview of those other estimates. Because there is no reliable way--short of a household survey--of confirming the actual number of uninsured in Hawaii, the percentage of low-income insured covered by the Medicaid options may actually be higher than 7 to 10 percent.
17. Assumes 21 working days in the month, at 8 hours per day. Also assumes a \$75 work expense deduction. Hourly wages could be higher if other deductions, such as child care, apply.
18. *Access to Health Care in the United States: Results of a 1986 Survey*, Special Report Number Two 1987. (Princeton, NJ: The Robert Wood Johnson Foundation), 1987; Lewin/ICF, 1988; Gail Wilensky and Mark Berk, "Health Care, the Poor and the Role of Medicaid," *Health Affairs* (Fall 1982:1), pp. 93-101.
19. Margo L. Rosenbach, "The Impact of Medicaid on Physician Use by Low-Income Children," *American Journal of Public Health* (September 1989:79:1220-1226).
20. *Ibid.*
21. Institute of Medicine. *Preventing Low Birthweight*. Report of the Committee to Study Prevention of Low Birthweight, Division of Health Promotion and Disease Prevention, Washington, D.C., 1985. Paul Braveman, M.D., et. al., "Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982 to 1986," *The New England Journal of Medicine*, August 24, 1989. Rachel M. Schwartz, "What Price Prematurity?", *Family Planning Perspectives*, vol. 21, no. 4, July/August 1989.
22. IOM, 1985.
23. Nicole Lurie, M.D. et. al., "Termination of Medi-Cal Benefits: A Follow-Up Study one Year Later," *The New England Journal of Medicine*, vol. 314, no. 19, May 8, 1986.
24. Steffie Woolhandler, M.D., M.P.H. and David U. Himmelstein, M.D., "Reverse Targeting of Preventive Care Due to Lack of Health Insurance," *JAMA*, vol. 259, no. 19, May 20, 1988.
25. John Billings and Nina Teicholz, "Uninsured Patients in District of Columbia Hospitals," study for the District of Columbia Hospital Association by Lewin/ICF, March 1989.
26. State Health Insurance Program Act, Act 378 (Session Laws of Hawaii 1989).
27. Assumes 21 working days in a month, at 8 hours per day. Also assumes a \$75 work expense deduction. Hourly wages may be higher if other deductions, such as child care expenses, apply.

APPENDIXES

APPENDIX A

ENROLLMENT TRENDS IN THE HAWAII MEDICAID PROGRAM

Enrollment in the Hawaii Medicaid program (including both the federal/state and state-only components) declined between 1979 and 1988. In recent months, however, there has been a slight increase in enrollment as new eligibility groups have been added to the program.

The number of persons signed up for Medicaid in Hawaii peaked in fiscal year 1977-78, when 95,609 persons were enrolled on an average monthly basis. Between fiscal year 1977-78 and fiscal year 1988-89, monthly average enrollees declined by 29 percent to a total of 67,621 (Exhibit A.1). Although the reasons for this decline cannot be sorted out completely, several developments during this period are consistent with the pattern of constrained eligibility:

- . Federal changes in AFDC eligibility in the early 1980s had the effect of reducing the number of persons with incomes who could qualify for the federal/state Medicaid program. These changes reduced AFDC eligibility for families with income throughout the United States.
- . Unemployment in Hawaii has declined markedly from 6.7 percent in 1982 to a level in 1989 of less than 3 percent. About 15,000 fewer persons were unemployed in 1988 than in 1982, undoubtedly reducing the need for AFDC and GA for many persons.
- . The major income standards used for determining eligibility--the AFDC Need and Payment Standards--were not adjusted for inflation during this period. Exhibit A.1 shows that the AFDC Need and Payment Standards were at about 69.0 percent of the poverty level in 1982, but declined to 53.5 percent of the poverty level by 1987.¹

The decline in Medicaid enrollment slowed during fiscal year 1988-89, and was reversed during the first five months of fiscal year 1989-90 (July through November), as shown in Exhibit A.1. The modest increase of about 2,000 enrollees in early fiscal year 1989-90 occurred despite a continuing downward trend in the rate and number of persons unemployed in the state. In part the reversal can be attributed to three recent state-initiated changes in eligibility.

1. Two income thresholds are used in determining AFDC eligibility (and hence Medicaid eligibility). First, the *Need Standard* is compared to a family's gross income as an initial eligibility screen. A family with a gross income higher than 185 percent of the Need Standard is disqualified for consideration. Currently, the Need Standard in Hawaii is set at 100 percent of the poverty level and increases with changes in the poverty threshold. If the family meets this first eligibility test, certain deductions and work incentive "disregards" are subtracted from their gross income. If the remaining figure is below the state *Payment Standard*, the family is eligible for AFDC and Medicaid. The Payment Standard in Hawaii is currently set at 62.5 percent of the Need Standard. Prior to July 1988, the *Need Standard* in Hawaii was at the same level as the *Payment Standard* and both were lower than the current 62.5-percent-of-poverty level.

Exhibit A.1

Medicaid Enrollment, Unemployment, and Changes in the AFDC Payment Standard

Hawaii, Fiscal Year 1978-1990

Fiscal Year	Average Monthly Enrollment		Unemployment Rate**	Monthly AFDC Need Standard (Family of Three)		Monthly AFDC Payment Standard (Family of Three)	
	Persons	Percent Change		Amount	Percent of Poverty	Amount	Percent of Poverty
1978	95,609	--	7.7%	\$468	--	--	--
1982	87,903	--	6.7	468	69.0%	\$468	69.0%
1983	84,399	-3.9%	6.5	468	62.9	468	62.9
1984	81,762	-3.1	5.6	468	59.4	468	59.4
1985	78,882	-3.5	5.6	468	57.7	468	57.7
1986	75,856	-3.8	4.8	468	55.2	468	55.2
1987	72,291	-4.7	3.8	468	53.5	468	53.5
1988	67,734	-6.3	3.2	515	57.8	515	57.8
1989	67,621	-0.2	3.0 (6/89)	929	100.0	557	60.0 (eff. 7/88)
1990	69,671*	+3.0	2.2 (9/89)	964	100.0	602	62.5 (eff. 7/89)

* Average monthly for first four months (July-October) of fiscal year 1990.

** Based on calendar year.

Sources: Hawaii Medical Service Association. Medicaid Report: Summary of the State of Hawaii's Medicaid Program Operations During the Period July 1, 1988 through June 30, 1989 (unpublished draft tables). Hawaii MMIS Reports, XIXRR515. U.S. Department of Labor.

First, in July of 1988, Hawaii raised significantly the income standards used to determine eligibility for AFDC, and linked the standards to future increases in the poverty level. The AFDC Need Standard was raised to 100 percent of poverty and linked to changes in the poverty level, and the AFDC Payment Standard was set at 60.0 percent of the Need Standard. The latter was raised again in 1989 to 62.5 percent of the Need Standard.²

As shown in Exhibit A.2, this change apparently had some impact on AFDC enrollment, which began to increase after July 1988 when the provision was implemented. Given that unemployment was still decreasing during 1988 and 1989 (Exhibit A.1), the number of persons on AFDC probably would have continued to decline in the absence of the elevated AFDC standards. Note that enrollment in the AFDC-Unemployed Parent program (AFDC-UP) *did* continue to decline during 1988 and 1989 as unemployment dropped. This population (two-parent families with an unemployed breadwinner) was, by definition, generally not affected by the new eligibility standards. To qualify as "unemployed," the breadwinner must be working less than 100 hours per month, resulting in a monthly income likely to be well below the old AFDC Standards.

A second factor in increased enrollment was the increase in Medicaid eligibility to include elderly and disabled persons under the poverty level, implemented in January, 1989. This expansion was extended even further later in 1989 when the federal government required a higher resource standard for "Qualified Medicare Beneficiaries" or persons with incomes up to poverty who qualify for Medicaid payment of Medicare copayments, deductibles, and premiums (federal Medicare Catastrophic Act of 1988).

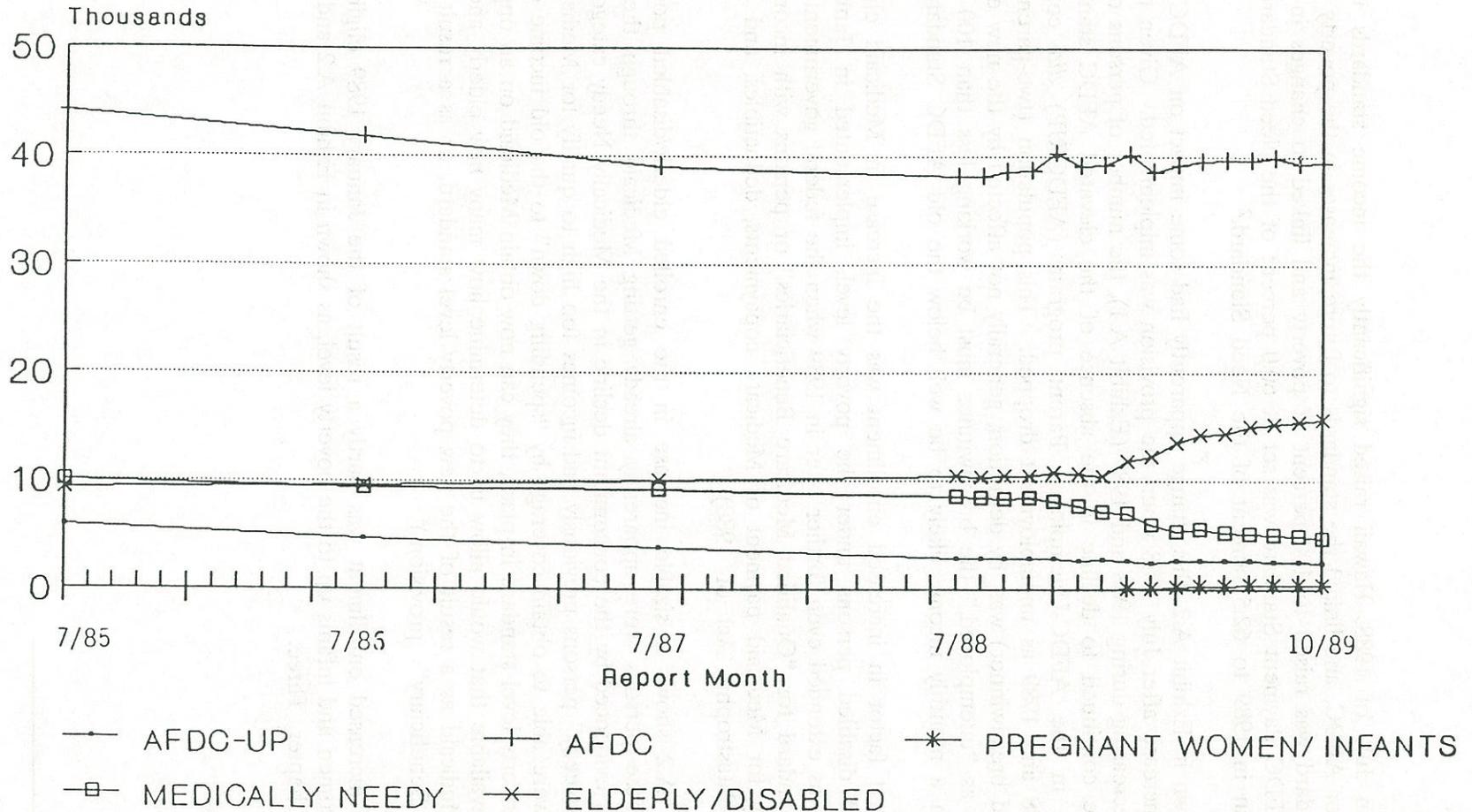
Exhibit A.2 shows a sizable increase in the enrolled elderly/disabled population, although many of these persons were apparently already getting Medicaid through the Medically Needy program, as evidenced by the concomitant decline in the Medically Needy category. These former "Medically Needy" persons previously had incomes too high to qualify for Medicaid on an ongoing basis, but were able to obtain coverage by "spending down" to the old income eligibility standard. With the poverty level standard in place, they can now obtain Medicaid on an ongoing basis. (Data were not available that would allow us to determine how many *new* elderly and disabled persons obtained Medicaid as a result of the new poverty level standard, or as a result of the "Qualified Medicare Beneficiary" provision.)

Finally, increased enrollment was partly a result of the January 1989 eligibility expansion to pregnant women and infants up to the poverty level, as shown in Exhibit A.2 and discussed in more detail in Chapter Three.

2. See footnote #1 for a more detailed explanation.*

EXHIBIT A.2

TRENDS IN HAWAII MEDICAID ENROLLMENT SELECTED ELIGIBILITY GROUPS JULY 1985 - OCTOBER 1989



SOURCE: Hawaii MMIS Reports, XIXRR515, "Title XIX Eligibility Recipients Report" for period 2/1/89 through 10/1/89. (Graph does not include all Medicaid eligibility groups.)

APPENDIX B

REQUIRED AND OPTIONAL SERVICES UNDER THE FEDERAL/STATE MEDICAID PROGRAM

MEDICAID SERVICES REQUIRED BY FEDERAL LAW

- . **Inpatient hospital services** other than services in an institution for mental diseases.
- . **Outpatient hospital services**, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services.
- . **Rural health clinic services.**
- . **Other laboratory and X-ray services.**
- . **Skilled nursing facility (SNF) services** (other than in an institution for mental diseases) for individuals 21 or older.
- . **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** for recipients under age 21. This includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.
- . **Family planning services and supplies.**
- . **Physicians' services** provided in the office, patient's home, hospital, skilled nursing home, or elsewhere.
- . **Home health services.**
- . **Nurse-midwife services** related to the management of the care of mothers and newborns when provided by a licensed nurse-midwife within the scope of practice authorized by state law.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration. *Health Care Financing: Program Statistics. Medicare and Medicaid Data Book, 1988.* (Baltimore, MD: April 1989).

MEDICAID SERVICES THAT CAN BE COVERED AT THE STATE'S OPTION

(Services covered in Hawaii are indicated by an asterisk *)

- * . **Medical or other remedial care provided by licensed practitioners** within the scope of practice as defined by state law. These practitioners may include, among others, podiatrists, chiropractors (limited coverage), and optometrists.¹
- . **Home health services** in addition to those required. These include physical therapy, occupational therapy, speech pathology, and audiology services.
- . **Private duty nursing services**, defined as nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician.
- * . **Clinic services**, that is, preventive, diagnostic therapeutic, rehabilitative, or palliative items or services provided to an outpatient by or under the direction of a physician or dentist in a facility that is not part of a hospital but that is organized and operated to provide medical care to outpatients.
- * . **Dental services** in addition to those required to be provided to persons under 21 years of age in the state's EPSDT program.
- * . **Physical therapy and related services.**
- * . **Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses.**
- * . **Other diagnostic, screening, preventive, and rehabilitative services.**
- . **Inpatient hospital services, SNF services, and intermediate care facility (ICF) services** to persons 65 years of age or over in institutions for tuberculosis or mental disease.
- * . **ICF services**, other than services in an institution for tuberculosis or mental diseases, for the physically ill or mentally retarded.
- * . **Inpatient psychiatric hospital services for persons under age 21.**
- * . **Other medical or remedial care recognized under state law.** Such additional items and services include transportation, emergency hospital services, nonprofessional personal care services prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoriums and nursing services, and SNF services for persons under 21 years of age.²

1. Hawaii does *not* cover services provided by chiropractors, but does cover services provided by other practitioners including optometrists and podiatrists.

2. Hawaii covers transportation, emergency hospital services, and SNF services for persons under 21 years of age *only*.

- * . **Home and community based services** (under waiver agreement) that an individual would need to avoid institutionalization.
- . **Case management services.**
- * . **Hospice services.**

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration. *Health Care Financing: Program Statistics. Medicare and Medicaid Data Book, 1988.* (Baltimore, MD: April 1989).

APPENDIX C

COST AND CASELOAD ESTIMATE METHODOLOGY FOR MEDICAID ELIGIBILITY EXPANSION

Cost and caseload estimates for the proposed Medicaid expansions were derived using the Lewin/ICF Health Benefits Simulation Model (HBSM). The HBSM estimates the impact of proposed changes in Medicaid eligibility by attempting to simulate the process of eligibility determination and enrollment behavior as closely as possible to actual program rules in Hawaii. The HBSM was programmed to use Hawaii-specific data from the Current Population Survey (CPS), which was collapsed over four years, and adjusted for changes in the CPS survey instrument itself in recent years. The methodology used in developing cost and caseload estimates is described below:

1. Use of the Current Population Survey

The Medicaid caseload estimates and estimates of the impact of Medicaid expansions on the uninsured population in Hawaii were based on data obtained from the Current Population Survey (CPS). The CPS is a household sample survey of the civilian non-institutionalized population conducted monthly by the Bureau of the Census to provide statewide and metropolitan area estimates of employment, unemployment, and other characteristics of the labor force, the population as a whole, and several subgroups of the population. The CPS also provides detailed demographic information on the distribution of uninsured persons by age/sex, income, and employment status.

2. Pooling of CPS Data

Because the size of the Hawaii subsample is relatively small, we pooled CPS data for 1984-1988 (excluding 1986 for which data were unavailable) to form a single data base suitable for detailed analysis of the demographics of the uninsured populations. Adjustments were made to the data to reflect changes in inflation and the poverty level to project the data to 1989 terms. Additional adjustments were made for changes in the Hawaii Medicaid eligibility rules. Since the format of the CPS has also changed over the years, some adjustment was made to the data base to reflect CPS shortcomings. Prior to 1988, the CPS overcounted the uninsured due to a different interpretation of the responses to a question on family insurance status. Thus, the Hawaii data from the years 1984, 1985, and 1987 were adjusted downward (controlling for age) to reflect the more accurate method of counting the uninsured used in the 1988 survey.

3. Estimating the Number of Persons Eligible for Medicaid

For each unit encompassed in the CPS data base, the model considers family income, assets, and family composition and compares them with the established criteria for Medicaid eligibility to determine current status and expected status under the proposed expansions. The estimate for the Medically Needy group assumes that children age 4-8 have already been covered under the proposed expansion to include "children up to poverty."

4. Estimating the Number of Persons Likely to Enroll in Medicaid

Not all persons eligible for Medicaid actually enroll in the program. We assumed that the ratio of currently enrolled to currently eligible persons in Hawaii would apply to the population newly eligible under the proposed expansions. This ratio, derived from the CPS data base, was determined controlling for age, sex, family income, and family size. As shown in Exhibit 3.5, two sets of numbers were estimated--persons enrolled at any point in time, and total persons enrolled during the year.

5. Estimating the Number of Persons Likely to Participate in Medicaid

Enrollment in the Medicaid program does not necessitate participation (use of services). Rate of participation depends upon the age, sex, family income, and family size of the enrollee. We assumed that rates of participation for these Medicaid demographic groups would match the U.S. average as indicated by national CPS data. Hawaii-specific estimates of this rate were not available.

6. Estimating Per Capita Costs for Program Users

To determine the appropriate cost per recipient figures to apply to the estimate of the number of new recipients, we used data from two sources. For children age 4-8 up to poverty, we used average annual cost per recipient for young children from the DOH estimates used to project cost for the MOMI program in support of H.B. No. 63.¹ This was \$620. For the Medically Needy populations, we used annual cost per recipient "Categorically Needy Receiving Maintenance Assistance," from Hawaii's Health Care Financing Administration (HCFA) Form 2082, FY1988. For the older children to be covered under Medically Needy (young children will already have been covered by the previous option) we used \$486, which is the average annual amount for children age 9-18 who did not receive services in an ICF or SNF (i.e., non-institutionalized recipients). For adults, we used \$995, which is the average annual amount for adults who did not receive services in an ICF or SNF (i.e., non-institutionalized).

Also included in the cost estimates was an estimate of new spend down expense created when elderly and disabled who currently qualify for Medicaid by "spending down" can now do so with a lesser spend down amount, creating additional costs for Medicaid. The new spend down expense was calculated by multiplying the number of elderly spend down cases from the HCFA Form 2082 for 1988 by the difference between the former Medicaid eligibility threshold for a single person and the new Medically Needy threshold. New spend down costs will also occur for many Medically Needy children and adults, but we assumed these would be offset by the reduction in spend down created when other spend down cases become eligible for the program on an ongoing basis.

1. Henry M. Ichiho and Dana Hughes. The MOMI Program: An Analysis of Medicaid Options for Mothers and Infants in the State of Hawaii submitted to the Hawaii State Department of Health, Family Health Services Division, August 20, 1987.

7. Estimating Total Program Costs

Total service costs for the proposed expansions were calculated by multiplying the estimates of new Medicaid recipients (i.e., persons who use at least one service) by the estimated cost per recipient described above. These costs were then projected forward to FY 1990-91, using a 6 percent annual inflation factor. Finally, administrative costs were added, based on an estimate produced by DHS for young children under poverty, which indicated total administrative costs of \$140.55 per family.² This amount was based on a second full year of implementation. Actual Administrative costs will be higher in the first year of implementation due to start-up costs. We assumed that the 3,000 new children under poverty enrolled during the year would represent about 2,000 families, and that the 2,350 new Medically Needy enrollees would represent about 1,175 families.

8. Estimating Costs to the State

A 54 percent federal match was assumed in determining costs to the state. This represents the level of federal financial participation for most Medicaid services in Hawaii; however, some services are reimbursed at a federal match of 90 percent, while the costs of administration are matched at 50 percent.

It should be noted that these estimates are based on a full year of implementation, with enrollment at the level that is expected in the long run. In actuality, however, it usually takes 18 months or more for enrollment in new eligibility groups to reach a plateau. Thus enrollment and program costs are likely to be lower in the first year of implementation. Administrative costs, however, will be higher in the first year due to start-up costs.

2. Memo dated October 11, 1989 from Winona E. Rubin, Director of the Hawaii Department of Health and Human Services, to Peter Sybinski, Deputy Director of the Hawaii Department of Health: "Administrative Cost to Process Eligibility of Families with Children Four Through Seven Years of Age."

APPENDIX D

SUMMARY OF PREVIOUS ESTIMATES OF THE UNINSURED IN HAWAII

There have been a number of efforts to estimate the number of uninsured in Hawaii. Estimates of the size of the uninsured population in Hawaii range from 3.9 percent to 19 percent of the population. However, none of these estimates was based on a comprehensive statewide household survey. The following summary of prior estimates is based on a Department of Health (DOH) report to the Hawaii State Legislature and interviews with persons who have participated in some of these efforts:

- . **1979 DOH Health Surveillance Program on the Cost of Medical Care in Hawaii.** Of a 4,000 person sample, it was found that 3.9 percent lacked some form of public or private health insurance. DOH based later estimates on this figure, applying the national rate of increase of the uninsured from the Robert Wood Johnson National Access Survey to the 3.9 percent to arrive at a 1986 estimate of 5 percent uninsured.
- . **1987 Omnitrack Research and Marketing Group Survey.** Omnitrack surveyed a sample of 400 Hawaii residents and reported an uninsured rate in the population of 5 percent.
- . Some attempts were made to estimate the number of uninsured in Hawaii using data from the **Current Population Survey (CPS)**. However, this evidence was discounted due to the survey's small sample size in Hawaii. One CPS estimate (from the 1985 data file) gave an uninsured figure of 19 percent for Hawaii, an otherwise unsupported statistic. The Employee Benefits Research Institute (EBRI), using 1986 CPS data, concluded that 11.8 percent of Hawaii's nonelderly population was uninsured.
- . Most recently, a **DOH survey of public school children** using emergency locator cards as the survey instrument has reported between 5 and 7 percent of the population surveyed as uninsured.
- . According to Professor William Wood of the **University of Hawaii**, an attempt by the University to develop an unduplicated count of the insured population estimated the uninsured population to be about 7.7 percent.
- . **The Lewin ICF analysis** of four pooled years of the CPS as described in Appendix C generated an estimate of about 9 percent uninsured.

APPENDIX E

ADMINISTRATIVE RECOMMENDATIONS CONSIDERED AND REJECTED DURING THE COURSE OF THIS STUDY

. **Creation of additional DHS staff positions in existing offices as needs arise.**

HCAD has already operationalized this option in its effort to obtain a MOMI coordinator. While this approach can be helpful on a program-by-program basis, it does not address the need for more comprehensive planning and monitoring. In addition, this option fails to address the fundamental coordination and planning problems that exist between DOH and HCAD.

. **Use of interagency coordinating committees to address individual issues.**

DOH and DHS currently utilize and have utilized interagency coordinating committees in the past to discuss particular issues, such as EPSDT, with mixed success. This experience has suggested that committee functions too easily become secondary to primary job functions for members, thus reducing the committee's effectiveness. The use of such committees also fails to establish a tone and policy for ongoing collaboration on more than just a few issues.

. **Transfer of the Medicaid program to DOH.**

The legislation authorizing this study raised the possibility of moving the Medicaid Program into DOH. Because this study was not designed to fully assess this option, we were not able to make a comprehensive determination of the advantages and disadvantages of this major organizational change. It was apparent from the more limited scope of this study, however, that there may be some advantages of a transfer such as linking similar programs (e.g., Medicaid and SHIP), adding emphasis on Medicaid-only options, and improving coordination of coverage, service delivery, and access issues. Among potential disadvantages are the fact that DOH currently does not appear to have the administrative or planning capacity to take over a program as expansive as Medicaid. Furthermore, we expect that the implementation of SHIP over the next two years will already strain DOH's current capacity. Finally, the link between Medicaid and cash assistance is still important (especially in terms of eligibility and enrollment functions), and a separation of the systems would be unwieldy.

. **Creation of a new planning agency or department outside of both DOH and DHS.**

The formulation of a planning agency overall unaffiliated with DOH and DHS has the distinct advantage of providing a mechanism transcending intra-agency tensions. However, there remains the need for improved cooperation between DOH and DHS which may only be realized through a fundamental change of behavior within both agencies.

GLOSSARY OF ABBREVIATIONS AND TERMS

AFDC

Aid to Families with Dependent Children. Federal/state program of cash assistance to low-income families. Income (after allowable disregards) must be below the state determined AFDC payment standard.

CPS

Current Population Survey, an annual survey of U.S. families conducted by the U.S. Bureau of the Census.

DHS

Hawaii Department of Human Services.

DOH

Hawaii Department of Health.

GA

General Assistance. Hawaii's State funded program of cash assistance to low income families and incapacitated individuals who are not eligible for AFDC.

HCAD

Health Care Administration Division of DHS. Division within DHS responsible for administration of the Hawaii Medicaid program.

HMSA

Hawaii Medical Service Association. Fiscal intermediary for the Hawaii Medicaid program.

MCH

Maternal and Child Health. Federal/State program administered by DOH.

Medicaid eligibles

Persons meeting current eligibility criteria for the Medicaid program.

Medicaid enrollees

Persons eligible for the Medicaid program who have applied and been approved for Medicaid.

Medicaid recipients/participants

Persons enrolled in the Medicaid program who use Medicaid services.

Medically Needy Program

Medicaid program optional to the states. Provides medical assistance to persons who would otherwise qualify for Medicaid as categorically needy if not for income and assets and to persons who incur high medical expenses which bring their monthly incomes below the medically needy standard. States determine the medically needy standard which may be up to 133-1/3 percent of their AFDC payment standard.

Medically Needy Standard

Monthly income limit below which one is eligible for Medicaid only. Currently equals the AFDC payment standard in Hawaii.

MIC

Maternal and Infant Care. Federal/State program administered by the DOH.

MOMI

Medicaid Options for Mothers and Infants. Recent Medicaid program expansion in Hawaii which raises the income eligibility limit for pregnant women and infants up to 100% of the poverty level. Also used to refer to new 100 percent income level for elderly and disabled.

SHIP

Hawaii's State Health Insurance Program.

Spend down

Process by which incurred medical expenses are counted against income to establish Medicaid eligibility as Medically Needy.

COMMENTS ON AGENCY RESPONSES

We transmitted a preliminary draft of this report to Department of Human Services (DHS) and the Department of Health (DOH) for comment on January 4, 1990. A copy of the transmittal letter to DHS is included as Attachment 1; the responses of DHS and DOH are included as Attachments 2 and 3, respectively.

Generally, the departments expressed agreement and support of the report and plan. They also raised some issues, largely technical in nature, which we respond to below.

DOH's Response

Of the three points questioned by DOH, we would like to note the following.

1. We have corrected the report to reflect the information provided in items #6 and #7. This has not affected the recommendations.
2. Case management activities targeted at families served by the Children with Special Health Needs Branch are included in the report under the discussion on the Public Health Nursing Branch's care coordination services. We did not include the Child Health Conferences because they are currently being reimbursed by Medicaid.

DHS's Response

DHS posed a number of questions and issues in its response. We hope the following comments provide some clarification.

1. Regarding general comment #1

We have revised the description of the study's scope in Chapter 1 of the final report to explain more explicitly the reasons for the focus on DOH programs. Briefly, DOH's services are the major factor when considering how to obtain federal Medicaid funds for services that are currently state-funded. The small amount of Medicaid reimbursements currently received by the State for DOH services, i.e., approximately \$110,000 annually (which includes the State's share and excludes reimbursements for DOH's institutional services), and the concern that additional services may be eligible for Medicaid reimbursement, are the reason for our study.

2. Regarding specific comment #1 concerning p. 6

We have corrected this item in the final report.

3. Regarding specific comments #2 and #3 concerning page 18

As noted in the report, we were informed by the Director of the Office of Payment Policy at HCFA that it is permissible to establish different classes of providers and pay them at different

rates. The Hawaii Medicaid program already does this. Under EPSDT, for example, private physicians receive \$95 per screening examination while the DOH Maternal and Child Health Clinics receive only \$34 per screen. Overall, DOH clinics are paid only nominal amounts under Medicaid. It is this situation that we recommend be changed. It is important that the State recognize that it can seek reimbursements up to cost (where it can be justified and approved by HCFA) to maximize federal financial support of Hawaii's health care programs.

Specifically, with respect to the "upper limits" on Medicaid reimbursement, federal regulations address this in two sections that may be relevant [please see 42 C.F.R. secs. 447.321, 447.325 (1988)]. First, the regulations require that Medicaid reimbursement for hospital outpatient and clinic visits be no more than that paid by Medicare for a comparable service in comparable circumstances. This requirement would seem to have little relevance for our recommendations since the clinic services in question are not covered by Medicare, and so could not be said to be comparable. Even if Medicaid and Medicare services were identical, HCFA indicated that Medicaid can pay higher rates if the service can be shown to be more expensive to provide to Medicaid clients than Medicare clients, e.g., that it is more difficult or time-consuming to perform on a child versus an adult.

Second, the regulations specify that for other outpatient services, Medicaid reimbursement can not exceed the prevailing charge in the community for a comparable service in a comparable setting. Most of the non-clinic DOH services we discussed simply are not otherwise available in the community. If increasing Medicaid reimbursements to cost (less an efficiency incentive) for DOH providers would cause it to exceed charges in the community, distinctions may be made under this regulation for services that can be shown to be more expensive to provide to Medicaid recipients because of age, setting of the service, or other factor.

While we believe that neither regulation would interfere with increasing Medicaid reimbursement to cover actual costs, we have clarified the discussion on page 18.

4. Regarding specific comment #4 concerning page 20

Services provided under the "rehabilitative services" benefit category, which could include physical therapy and occupational therapy, do not require physician prescription [please see 42 C.F.R. secs. 440.110, 440.130 (1988)].

5. Regarding specific comment #5 concerning page 22

See our comment #14 below.

6. Regarding specific comment #6 concerning p. 42

As explained in the report, an exception to the general rule allows states to specify providers of targeted case management services for the developmentally disabled and mentally ill (see state Medicaid manual transmission from HCFA on targeted case management). Thus, the State can deny participation to programs such as ARC and the Research Center of Hawaii.

7. Regarding specific comment #7 concerning p. 45

The issue discussed here is not whether Medicaid eligible children are receiving rehabilitative therapy, but, that these DOH services provided to Medicaid eligible children are *not being billed* to Medicaid and therefore are not being reimbursed by Medicaid. Currently, physical rehabilitative services such as physical and occupational therapy are available to children under Hawaii's Medicaid state plan, but, only if provided in certain rehabilitation facilities, not in schools.

8. Regarding specific comment #8 concerning p. 78

DHS staff have informed us that its adjusted counts of enrolled pregnant women and infants shows that Hawaii's MOMI enrollment is closer to DHS projections than presented in Exhibit 3.6 of the report (the exhibit is based on unadjusted counts). The basic conclusion that there has apparently been a leveling off of enrollment remains unchanged.

9. Regarding specific comment #9 concerning p. 80

We are pleased that progress has been made in recruiting additional presumptive eligibility providers.

10. Regarding specific comment #10 concerning p. 104

We agree that appropriate data bases and monthly reports are available within DHS for monitoring of enrollment trends. The problem is that there is *no regular process* in place for periodically *compiling, analyzing, and reporting on trend data* from these monthly reports for targeted eligibility groups. Thus, for example, we found it necessary to construct from individual monthly reports the trends in MOMI enrollments shown on p. 78. Our intent is to encourage DHS to construct similar trend analyses on a regular basis in order to keep current on enrollment for new eligibility groups.

11. Regarding comment #2 concerning the recommendation in chapter two on coverage of OT and PT for special education students

See our comment #7 above.

12. Regarding comment #3 concerning the recommendation in chapter two on coverage of mental health services to students and adults

While the Hawaii Medicaid program already covers clinic-based mental health services, it does not cover mental health services provided in other settings, such as the home or school, that are needed for severely emotionally disturbed children and adolescents. Also, Hawaii's program has no specific reimbursement policy for day treatment program--DOH's primary service for severely disabled mentally ill adults. DOH mental health centers are permitted to bill only for one individual or group therapy visit per day for a maximum of \$14 per visit which would cover only a very small portion of these services.

13. Regarding comment #4 concerning the recommendation in chapter two on coverage of certain public health nursing services

Our recommendation to cover nurses as independent practitioners for the purpose of patient training and education extends beyond the coverage of pediatric nurse practitioners mandated by OBRA '89.

14. Regarding comment #5 concerning the recommendation in chapter two on federal financial participation (FFP) for family planning services

We are pleased to hear that, contrary to what we understood, family planning visits provided by clinics can be tracked and that the 90 percent FFP is being obtained by Hawaii for these services. Accordingly, we have removed all references to this issue from the report.

15. Regarding comment #6 concerning the recommendation in chapter two on increasing reimbursements

As explained above in our comment #3, DHS would not be required to change the reimbursement rates of non-DOH funded clinics.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813



(808) 548-2450
FAX: (808) 548-2693

January 4, 1990

C O P Y

The Honorable Winona E. Rubin
Director of Human Services
Department of Human Services
1390 Miller Street, Room 209
Honolulu, Hawaii 96813

Dear Mrs. Rubin:

Enclosed are three copies, numbers 6 to 8 of the draft report, **Study and Plan for Maximizing Federal Medicaid Funds for Hawaii**. This report was prepared by the consulting firms of Lewin/ICF and Fox Health Policy Consultants. We ask that you telephone us by January 8, 1990, on whether you intend to comment on our recommendations. Should you decide to respond, please transmit the written comments to us by January 18, 1990. We will append your response to the report submitted to the Legislature.

The Director of Health, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since the report is not in final form and changes may be made, access to this report should be restricted to those whom you might wish to assist you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Newton Sue
Acting Legislative Auditor

Enclosures

ATTACHMENT 2



WINONA E. RUBIN
DIRECTOR

ALFRED K. SUGA
DEPUTY DIRECTOR

MERWYN S. JONES
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809

January 19, 1990

RECEIVED

JAN 19 10 20 AM '90

OFFICE OF THE AUDITOR
STATE OF HAWAII

MEMORANDUM

TO: Newton Sue, Legislative Auditor
Office of the Legislative Auditor

FROM: Winona E. Rubin, Director

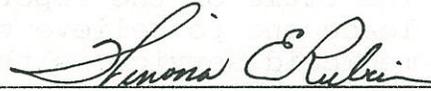
SUBJECT: COMMENTS ON "STUDY AND PLAN FOR MAXIMIZING FEDERAL
MEDICAID FUNDS FOR HAWAII"

We have reviewed the draft report prepared by Lewin/ICF and Fox Health Policy Consultants. We appreciate the opportunity to comment on the draft. The recommendations contained in the report will be the basis for our department's initiative in improving coordination within the department and with the Department of Health and other private agencies.

One of the department's missions has been to provide quality health care to those unable to afford such care in a cost effective manner. Therefore, the maximization of federal funds has always been a primary means to achieve this goal. With the complexity and enormity of the Medicaid Program, it appears that we have not been able to "cover all bases". This report and its recommendations will assist us in the maximization of federal medicaid funds for services provided by the Department of Health to the extent that the recommendations do not jeopardize the Medicaid Program in general.

We have attached, for your information, general comments and more specific technical comments relative to the study and its recommendations.

We take this opportunity to express our appreciation for the courteous and sensitive manner in which your analyst and consultants approached this study. The constructive manner in which this report is presented is commendable. If there are any questions or clarifications regarding our comments, please contact Winifred Odo at 548-3855.


Director

Attachment

- cc: DDIR/AS
- DDIR/MJ
- DOH-DDIR/Peter Sybinsky
- A-FASDA
- PD-IM (H. Onoye)
- PLNG

COMMENTS ON "STUDY AND PLAN FOR MAXIMIZING
FEDERAL MEDICAID FUNDS FOR HAWAII"

GENERAL COMMENTS:

1. The title of the report and its accompanying report leads one to believe that the major provider of medicaid service is the Department of Health. In reality, in FY 89, medicaid's expenditure for DOH services totalled \$113,411 (excluding state hospital reimbursements). In comparison the total medicaid expenditure for the same period was in excess of \$214 million. It is important that an explanation of the enormity of the Medicaid Program and the limited focus of the study be explained in the introduction to put this study into proper perspective.
2. The recommendations contained on Chapter 4, Administrative Assessment are good ones and the department agrees that better coordination within our department, with DOH and community groups is needed. Both DHS and DOH can benefit from improved communication, coordination and cooperation. Within the last few years, both departments have worked harder towards this end and are committed to continue this effort.

SPECIFIC COMMENTS:

1. Page 6 - The medically needy eligible recipients are not temporarily eligible. As long as they meet the income and assets criteria and apply their spenddown, they continue to be eligible. There is no such thing as temporary 6 months eligibility.
2. Page 18 - The recommendation that the medicaid program reimburse DOH-funded providers the actual cost of delivering services while reimbursing private providers on the UCR is contrary to comparable reimbursement for same type of services and is discriminatory in practice. It has always been the department's position that providers should be treated equitably. Additionally, the federal government has mandated an imposition of upper limits to medicaid reimbursement. If the actual cost for DOH funded services exceeds the upper limits, medicaid would face tremendous disallowances for non-compliance.

3. Page 18 - Suggest the favoring of public providers (DOH). This is clearly discriminatory in practice and unacceptable to HCFA and the department.
4. Page 20 - States rehabilitative services need not be physician prescribed or directed. The Code of Federal Regulations states that coverage of OT and PT must be prescribed by a physician.
5. Page 22 - Inference that Hawaii is not claiming full FFP for family planning services is puzzling. Hawaii has been claiming 90-10 ever since it was available.
6. Page 42 - States "no potential for unintended medicaid costs associated with". Study has overlooked programs such as Research Center of Hawaii and ARC which will also want payment for such services.
7. Page 45 - Medicaid eligible children are being provided rehabilitative therapy as long as the service is physician prescribed.
8. Page 78 - Attached data on MOMI enrollment produced by HAWI is available for analysis and trends.
9. Page 80 - Presumptive eligibility providers are available on Oahu, Hilo, Kohala, Kauai and Molokai. (Not limited to Oahu and Hilo as study indicates.)
10. Page 104 - Reference is made that DHS has not set up a data base "to produce regular reports on enrollment trends...". The HAWI Monthly Caseload Summary Report provides a breakdown of categories (including MOMI) of the number of applications received during the month and the caseload count at the end of the month, in addition to other information on enrollment trends. There is also a MOMI Presumptive Eligibility Reports to capture data on enrollment through the qualified provider route.

COMMENTS ON RECOMMENDATIONS: CHAPTERS 2 & 3

1. Adopt Medicaid's targeted case management benefit to cover care coordination services furnished to a number of medically complex, developmentally disabled, mentally ill, and other high-risk populations served by DOH programs.

DHS is in the process of developing administrative rules to cover targeted case management under the Medicaid Program.

2. Permit Medicaid coverage of occupational therapy and physical therapy services delivered to special education students under Hawaii's existing Medicaid ancillary therapy benefits.

OT and PT services to special education students who are medicaid eligible has been developed.

3. Expand its Medicaid definition of rehabilitation services to permit coverage of mental health services to students with emotional problems and to adults with severe emotional disability.

Mental health services have been available to medicaid eligible students and adults as long as the mental health rehabilitation services are prescribed by the physician or therapy by a certified psychologist. Mental health services have been available for approximately 17 years.

4. Adopt Medicaid coverage of certain public health nursing services under the independent licensed practitioner benefit.

Hawaii Nurses Association and DHS are developing administrative rules related to nurse practitioners. OBRA 89 mandates medicaid coverage of pediatric nurse practitioners. DHS is currently awaiting receipt of a copy of the provisions of OBRA 89.

5. Assure that DOH's claims to Medicaid for reimbursement for family planning services are made under the family planning category, which provides for substantially greater federal financial participation.

Claims are submitted on the diagnostic codes rather than procedure codes. Based on these claims submissions, the DHS accounting office claims 90% FFP for family planning services. DHS has offered to provide DOH programs training on claims submissions conducted by our fiscal agent.

6. Increase its Medicaid reimbursement rate for clinic services to reflect the actual DOH service costs.

DHS will explore the financial impact as the rate increase may include approximately 21 non-DOH clinics which include Waikiki Health Center, Queen Emma Clinic, St. Francis Outpatient Clinic, Kapiolani Outpatient Clinic, Kokua Kalihi Valley, etc.

7. Require DOH providers of services to bill Medicaid for all Medicaid-reimbursable services.

DHS has noted the low level of DOH medicaid billings in the past and has encouraged increased billings.

COMMENTS ON RECOMMENDATIONS: CHAPTER 4

1. Expand eligibility to include all children age four to eight up to poverty level.

DHS has implemented such coverage effective January 1, 1990 with funds transferred from DOH's SHIP appropriations.

2. Raise the medicaid income eligibility standard to the maximum allowed under federal law where it would not incur additional welfare expenditures.

DHS is currently exploring several eligibility expansion options. (133% of AFDC for medicaid, JOBS incentive option)

3. Undertake efforts to enhance enrollment in existing and future medicaid-only eligibility categories.

- a. "Short form" application is being developed.
- b. Out-stationing eligibility workers is presently being negotiated. The department will continue its efforts to make the programs more accessible to the public.
- c. Recruitment of qualified providers to determine presumptive eligibility is an on going task. As indicated in the study, the federal guidelines for qualified providers is so specific that it has become a deterrent to approving potential providers.

4. Ensure that SHIP is well coordinated with Medicaid.

DHS and DOH personnel have been working together in ensuring that SHIP and Medicaid coverage groups and services are complementary. DHS is committed to utilizing the Medicaid Program to maximize federal funds to alleviate the financial burden on SHIP. DHS realizes the importance of adequate coordination, therefore, has a request for a SHIP/Medicaid Coordinator position request in our supplemental budget request.

REPORT ID: XIXRRS15
 PROGRAM ID: XIX016
 JOB/STEP : XIXQ001A/K#09#89

HAWAII MMIS
 TITLE XIX ELIGIBLE RECIPIENTS REPORT

PAGE NO: 64
 RUN DATE: 11/07/89
 TIME: 23:22:02

9/01/89
 MANDATORY COVERAGE GROUPS
 SUMMARY

CATEGORY	TOTAL CASES	* W/1	* *	* W/2	* *	CASES W/3	* W/4+	* *	* W/OUT	ADULTS	CHILDREN	RECIPS
CP	684	576		82		2	0		24	495	251	746
CP - KAIPRO	2	2		0		0	0		0	2	0	2
CP - RRP	0	0		0		0	0		0	0	0	0
CP - RRP-G	0	0		0		0	0		0	0	0	0
QB	0	0		0		0	0		0	0	0	0
QB - KAIPRO	0	0		0		0	0		0	0	0	0
QB - RRP	0	0		0		0	0		0	0	0	0
QB - RRP-G	0	0		0		0	0		0	0	0	0
SUBTOTAL	686	578		82		2	0		24	497	251	748

REPORT ID: XIXRRS15
 PROGRAM ID: XIX016
 JOB/STEP : XIXQ001A/L#10#89

HAWAII MMIS
 TITLE XIX ELIGIBLE RECIPIENTS REPORT

PAGE NO: 64
 RUN DATE: 11/07/89
 TIME: 23:35:49

10/01/89
 MANDATORY COVERAGE GROUPS
 SUMMARY

CATEGORY	TOTAL CASES	* W/1	* W/2	* W/3	CASES W/3	* W/4+	* W/OUT	ADULTS	CHILDREN	RECIPS
CP	598	531	56	1	0	10	415	231	646	
CP - KAIPRO	4	3	1	0	0	0	4	1	5	
CP - RRP	0	0	0	0	0	0	0	0	0	
CP - RRP-G	0	0	0	0	0	0	0	0	0	
QB	2	2	0	0	0	0	2	0	2	
QB - KAIPRO	0	0	0	0	0	0	0	0	0	
QB - RRP	0	0	0	0	0	0	0	0	0	
QB - RRP-G	0	0	0	0	0	0	0	0	0	
SUBTOTAL	604	536	57	1	0	10	421	232	653	

ATTACHMENT 3



JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH

P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: DDHRA

January 17, 1990

Mr. Newton Sue
Acting Legislative Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

RECEIVED
JAN 18 10 54 AM '90
OFFICE OF THE AUDITOR
STATE OF HAWAII

Dear Mr. Sue:

Draft Report
Study and Plan for Maximizing Federal Medicaid Funds for Hawaii

Thank you for the opportunity to comment on your agency's draft report, **Study and Plan for Maximizing Federal Medicaid Funds for Hawaii**, prepared by the consulting firms of Lewin/ICF and Fox Health Policy Consultants.

In general, we are very pleased with the report. While we must necessarily leave technical comments with respect to specific recommendations to our sister agency, the Department of Human Services, we believe that the plan of action outlined in the report will be a valuable tool to assist the State in achieving the best utilization of the federal Medicaid program. We deeply appreciate the efforts expended in putting together the report. Staff from both the Auditor's Office and Lewin/ICF correctly recognized that a successful Medicaid program will be a partnership which includes the cooperative efforts of the Departments of Human Services and Health and the entire Executive Branch as well as the Legislature and its attached agencies. The project was done cooperatively by all parties and we believe that the thoroughness of the report as well as the cooperative atmosphere in which it was engendered provides a good basis for the many actions that must be undertaken if Hawaii is to maximize its benefit from the Medicaid program.

We do have some specific comments with respect to the report:

1. We agree, if funds are available, that expansion of Medicaid to cover the medically needy is both viable and cost-effective since the expansion of

Medicaid to serve this group (and potentially 0-6 year old children up to 133% of poverty) would allow the thorough benefits of Medicaid to be applied to a population which is in need.

2. We are also in strong accord with the shortening of the Medicaid application form. We believe that a shortened form would increase access to the Medicaid program for many people as well as open new options in program delivery. We understand that the Department of Human Services is looking into such a shortening and we will assist them in any way possible. We are incidentally consciously attempting to develop the application for our State Health Insurance Program (SHIP) to be as brief as possible yet to allow for close coordination of SHIP with Medicaid.
3. Out-stationing eligibility workers is an excellent idea. Given the many administrative constraints to out-stationing, we would certainly be in favor of more community-based delivery if this is at all possible.
4. We strongly believe in coordination of the Medicaid program with SHIP. The staffs of the two agencies are working on common problems and seeking to make the programs as compatible as possible. We have structured SHIP to allow for easy access for Medicaid recipients who leave the Medicaid role and are exploring ways in which service delivery staff might cooperate in sharing information, processing applications and, in general, providing a compatible fit between the two programs. Since it is the objective of SHIP to deal with the gap, both by providing for those in the gap group directly and by working to improve both Medicaid and Prepaid Health Care, we have taken note of the many suggestions in your report and hope to incorporate them to the maximum extent possible into SHIP.
5. We also support your report's recommendation that the Department of Health develop a centralized billing capability. The individual programs, particularly Behavioral Health Services and Personal Health Services, are enthusiastically beginning to deal with the billing question. We believe that the revenue estimates given in your report for mental health actually underestimate what might be achieved by a good billing system. Such a system is dependent upon improvement of our Department's information gathering capabilities, a deficit you have also noted in your report. We intend to address this question extensively in the next biennium. Until that time, we will be doing all we can within current resources, particularly in mental health and developmental disabilities.

6. On page 25, the report refers to maternal and child health clinics which employ physicians. Most of the physicians are contracted with by the Department and not employed directly by the Department.
7. On pages 43 to 45, the report refers to the provision of occupational and physical therapy to special education students by the School Health Services Branch under an agreement with the Department of Education; however, the Branch is obligated to provide these services at no cost to the parents under State statute. The Department of Health will examine an amendment to the code to permit billing Medicaid for such services.
8. The report does not mention services provided by the Public Health Nursing Branch under the case management activities described under the Children with Special Health Needs Branch. In addition, the Title V clinical services include the Child Health Conferences, which are collaboratively conducted by the Maternal and Child Health Branch, Public Health Nursing Branch, and Epidemiology Branch and provided to a significant number of Medicaid-eligible clients.
9. The Developmental Disabilities Division is pursuing Medicaid reimbursement for Infant Development Programs previously funded under Title XX. Recently, the 0-3 Early Intervention Project applied for P.L. 89-313 funding under new regulations through the Department of Education for all infants enrolled in State programs. In addition, a State Plan amendment for targeted case management for persons with developmental disabilities has been initiated with the Department of Human Services.

We appreciate the recognition of the Department of Health and the Department of Human Services efforts thus far on the Medicaid problem. Our partnership has resulted in 1) initiation of the MOMI Program for pregnant women and infants in 1987; 2) support for MOMI's expansion; 3) transfer of funds from the SHIP to fund for fiscal year 1990 Medicaid for children ages 4-8; 4) inclusion of the expansion of Medicaid for children 4-8 in the Governor's Supplemental budget request; 5) initiation of the Medicaid Task Force within the Department; and 6) efforts to coordinate with Medicaid and maximized usage of Medicaid in SHIP.

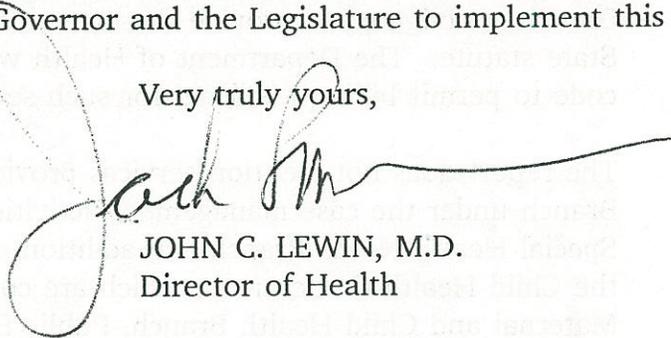
Your report correctly notes the amount of staff work needed to implement the changes the report recommends. While we are committed to using this report as a blueprint for maximizing Medicaid, we must note that additional staffing for this effort in our Department would enable us to implement these changes as soon as possible. With potential cutbacks in Medicaid a continuing possibility, we believe such additional staff would be a cost-effective investment for the State to make. We would

hope similarly that the Department of Human Services be provided with staffing to assist in the development for the overall Medicaid program.

To reiterate, our Department believes that the report done by your staff and Lewin/ICF and Fox Health Policy is a viable blueprint and will result in a cost-effective expansion of Medicaid and the best use of general fund resources for health purposes. We appreciate the efforts expended and look forward to working with the Department of Human Services, the Governor and the Legislature to implement this blueprint.

Very truly yours,

Thanks very much.



JOHN C. LEWIN, M.D.
Director of Health

