Audit of the Department of Human Services' Expedited Application Process for Pregnant Women

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

Report No. 04-12
December 2004

THE AUDITOR
STATE OF HAWAII

The Office of the Auditor

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2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

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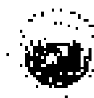

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OVERVIEW

Audit of the Department of Human Services' Expedited Application Process for Pregnant Women

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Summary

The Department of Human Services' Med-QUEST Division is responsible for managing the State's medical assistance programs through Medicaid fee-for-service and a managed care program called QUEST. Prior to 1994, pregnant women who sought medical assistance were presumed eligible to receive immediate prenatal care. Permanent Medicaid eligibility was determined at a later date. With the 1994 establishment of Hawaii QUEST the presumptive eligibility standard was eliminated and pregnant women had to proceed through the ordinary eligibility screening. Pregnant women and their advocates have expressed concern that this lengthy process may delay access to prenatal care, thereby negatively impacting birth outcomes. To address this concern the department established an expedited application process in 2004, asserting that it would process 95 percent of completed applications from pregnant women within five business days.

The department has maintained statistics indicating that it was in compliance with the self-imposed processing standard of processing. We found, however, that despite making notable improvements in processing applications, the department fell short of its self-imposed standard. We tested sample application files on Oahu and Maui and found that Oahu achieved, at most, a 71 percent compliance rate, while Maui attained a 100 percent compliance rate. We note that current administrative rules provide no penalty for failing to comply with the standard, giving little incentive for staff to comply.

Contributing to the division's non-compliance was Oahu's Benefit, Employment and Support Services Division's (BESSD) failure to consistently transfer pregnant women applications to the Med-QUEST Division for processing. Our testing of sample applications on Oahu revealed that BESSD was responsible for seven delays, averaging 18.4 days to process applications from pregnant women.

We also found that the Med-QUEST Division does not apply the five-day standard uniformly among its units. Division staff and supervisors we interviewed interpreted the application standard differently. As a result, pregnant women throughout the State were subject to varying application processing times. Applications submitted by federally qualified health centers were also subject to varying standards.

Adding to the department's false sense of accomplishment was its reliance on flawed statistical calculations. We found that statistics maintained by division staff did not reconcile with those calculated by the division's computer database. Unlike computer calculations, the division excluded applications processed by BESSD in calculating compliance with the five-day standard; the division also included in its calculations applications from pregnant women who were already receiving medical benefits. As a result of the inappropriate inclusions and

exclusions, the department relied on skewed figures in making its assertions of compliance with the five-day standard.

We were also asked by the Legislature to analyze whether a return to presumptive eligibility would yield significant additional benefit to pregnant women. Although presumptive eligibility is utilized in 32 U.S. states and territories, we found that the current expedited application process is probably better than presumptive eligibility. Advocacy groups and public organizations point to local and national studies that laud early prenatal care as a means to address Hawaii's rising number of low birth-weight babies. However, medical research finds the connection between early prenatal care and positive birth outcomes inconclusive.

As part of our research, we surveyed 655 local obstetrician-gynecologists, pediatricians, general and family practitioners, and other related medical professionals regarding the current expedited application process and presumptive eligibility. We found that the five-day application period does not pose a medical hardship to women and that obstetricians average six days before seeing a new client. We also found that some practitioners currently limit or refuse Medicaid clients, and that some practitioners are unlikely to participate as qualified providers under a presumptive eligibility scheme. Overall, practitioners responding to our survey were split on the need for presumptive eligibility, but confirmed that lack of insurance is the most significant barrier to prenatal care in Hawaii. Finally, we found that the State would likely incur higher costs under presumptive eligibility. Our findings suggest that presumptive eligibility may actually become a barrier to early prenatal care.

Recommendations and Response

We made several recommendations to help improve the Med-QUEST Division's processing of applications from pregnant women. Among these, we recommended that the department evaluate data-gathering methods and develop a consistent and accurate reporting system, disseminate written instructions clarifying the five-day process, and ensure consistent application of the standard. We also suggested that the department propose an administrative rule amendment that would codify the department's current practice and that it submit a report to the 2006 Legislature regarding improvements made. Finally, we suggested that, if the Legislature determines that presumptive eligibility is necessary, it ensures that stakeholders work together to gain the buy-in by medical providers in the community and that adequate resources are available to support the program.

In written comments on a draft of our report, the department agreed with our finding that improvements have been made and that presumptive eligibility may not serve as a better alternative to expedited application processing. The department also concurred with the recommendations and outlined corrective actions already taken. The department also made clarifying points, but was in general agreement with our findings. We incorporated some of those points of clarification in the final report.

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Submitted by

THE AUDITOR
STATE OF HAWAII

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Foreword

This report examines the Department of Human Services' expedited application process for pregnant women seeking Medicaid or QUEST assistance pursuant to Senate Concurrent Resolution 54 of the 2004 Regular Session. Our review assessed whether the department is meeting its objective to process 95 percent of completed applications from pregnant women within five business days, the adequacy of the application process, and the potential of presumptive eligibility.

We wish to express our appreciation for the cooperation and assistance extended to us by officials and staff of the Department of Human Services and others whom we contacted during the course of this audit.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

The 2004 Legislature directed the Auditor, through Senate Concurrent Resolution No. 54, to:

1. Assess the impact of the Department of Human Services' expedited processing of applications from pregnant women seeking Medicaid or QUEST coverage on early entry into prenatal care and subsequent birth outcomes;

2. Evaluate the impact of the department's expedited processing on reducing the waiting period for Medicaid or QUEST enrollment and the beginning of prenatal care;

3. Assess the current expedited processing against presumptive eligibility with respect to timely access to and utilization of prenatal care;

4. Conduct a quality assurance survey of public and privately-funded prenatal care providers to determine provider satisfaction with implementation of this standard;

5. Assess the impact of the expedited processing on the timely review and determination of eligibility of applications received from applicants that are not applying through the expedited process; and

6. Append any proposed legislation if we determined such legislation to be necessary.

Background

Medicaid has provided medical insurance coverage for over 1.4 million low-income pregnant women in the U.S. in 1999 and 2000. During the past two years, Medicaid has covered over 6,000 pregnant women in Hawai`i. Prior to 1994, Hawai`i employed a presumptive eligibility standard that allowed women to receive immediate prenatal care. Permanent Medicaid eligibility was determined at a later date. With the 1994 establishment of Hawai`i QUEST (a managed care program), the presumptive eligibility standard was eliminated and applications from pregnant women were subjected to the same eligibility review as other assistance requests. Since then, pregnant women and their advocates have expressed concern that the lengthy process for eligibility determination may negatively impact birth outcomes. To address these

concerns, in 2004 the department established an expedited application process for pregnant women seeking Medicaid assistance.

History of providing medical assistance to qualified pregnant women

Since the 1980s, Congress has enacted numerous laws concerning Medicaid eligibility for children and pregnant women. Medicaid is one of the largest providers of insurance for prenatal care, covering almost 37 percent of the nation’s births. Medicaid assists one in ten women and more than half of low-income pregnant women. In Hawai`i, Medicaid coverage for pregnant women is provided through Hawai`i QUEST.

Medicaid

Medicaid covers medical assistance for certain individuals and families with low incomes and limited resources. This state-administered program became law in 1965 and is funded by federal and state governments. Each state’s Medicaid program differs, reflecting priorities in coverage and benefits within the substantial flexibility afforded states under federal law.

Within the federal structure, each state enrolls beneficiaries using its own eligibility criteria, decides the services to cover, and sets payment rates for providers. A state also decides other key policies, such as which eligibility groups are to receive care within a managed care system, how the state will use Medicaid to finance a range of medical services, and whether special payments are to be paid to hospitals that serve a disproportionate share of indigent patients. While the federal government requires a participating state to provide a core of benefits, it also allows state discretion to provide “optional” services.

The federal government and the states share responsibility for financing Medicaid. The federal government matches state spending on an open-ended basis for the services Medicaid covers. The federal matching rate, known as the federal medical assistance percentage (FMAP), varies by state. Based on state per capita income, the FMAP currently ranges from 50 percent to 77 percent. On average, the federal government pays 57 percent of states’ Medicaid expenditures.

Medicaid is one of the largest providers of insurance coverage for prenatal care. In calendar year 2000, Medicaid covered 1,464,742 births in the U.S., or nearly 37 percent of all births. During that year, Medicaid covered 6,080 births in Hawai`i, or 35 percent of all births. The number of Medicaid-covered births in Hawai`i has risen by over 7 percent annually from 2001 through 2003. Exhibit 1.1 illustrates the growth in the number of Medicaid-covered births in Hawai`i.

Exhibit 1.1
Number of Pregnant Women Participating in the Medicaid Program, CYs2001-2003

Year	Number of participants	Percent increase from the previous year
2001	5,647	-----
2002	6,080	7.7 percent
2003	6,510	7.6 percent

Source: Department of Human Services

Presumptive eligibility under MOMI

Prior to 1994, the Department of Health provided assistance to pregnant women under the Medicaid Options for Mothers and Infants (MOMI) program, which utilized a “presumptive eligibility” feature. Under general presumptive eligibility guidelines, a qualified health care provider could review a pregnant woman’s preliminary income information and presume she would be eligible for state-sponsored health coverage. Medical coverage would begin, and care could be sought immediately. The State would then have 45 days to determine the applicant’s permanent eligibility for Medicaid assistance based on a more thorough review of income, residency, and other requirements. In 1994, the QUEST program, administered by the Department of Human Services, replaced the MOMI program and eliminated the use of presumptive eligibility.

Introduction of QUEST

The State wanted to reform its Medicaid program and devised an acronym—QUEST—to describe the program.

QUEST is an acronym that represents:

Quality care, ensuring
Universal access, encouraging
Efficient utilization,
Stabilization costs, and
Transforming the way health care is provided.

Each state is allowed to reform its Medicaid program under Section 1115 of the Social Security Act, which outlines requirements for experimental, pilot, or demonstration projects by states. It allows the U.S. Secretary of Health and Human Services to waive compliance with any requirements of certain statutory provisions, including those pertaining to Medicaid, for any project that would promote the objectives of the Social Security Act.

In July 1993, the Health Care Financing Administration, the federal agency responsible for Medicaid, approved Hawai`i's Medicaid Section 1115 waiver application to provide Medicaid services through managed care plans. This program was called QUEST. The waiver covered the period from April 1, 1994, through March 31, 1999, and was subsequently extended through March 31, 2005. In August 1994, the QUEST program combined enrolling participants from the Aid to Families with Dependent Children, the General Assistance, and the State Health Insurance programs. Under the QUEST program, the Med-QUEST Division of the Department of Human Services contracts with selected private health plans to provide medical services to participants. The division pays a monthly capitated rate to the health plans, which must provide the required range of comprehensive services through contracts with providers. Reimbursement methodologies between the health plans and providers may include fee-for-service or capitation arrangements, or a mix of both. Fee-for-service refers to health coverage in which doctors and other providers receive a fee for each service. The plan will either pay the medical provider directly or reimburse the individual directly. Capitation refers to a payment of a per capita amount for a defined package of health care services. A specific dollar amount per member, per month, is paid to providers that provide specific services, regardless of the quantity of services necessary to meet the health needs of the defined population.

Proposed restoration of presumptive eligibility

In 2003, the Legislature considered legislation to restore presumptive eligibility for pregnant women applying for medical assistance. Under the proposed legislation, House Bill No. 122, Senate Draft 2, Regular Session of 2003, the department could provide early and continuous medical care for pregnant women by establishing presumptive eligibility for Medicaid fee-for-service or QUEST coverage for prenatal care or other medical services related to pregnancy. Additionally, the department would presume that a pregnant woman applying for pregnancy-related fee-for-service or QUEST was eligible for coverage, provided that she met income requirements and submitted proof of pregnancy. The department would then have 45 days to review her eligibility for continuing coverage under fee-for-service or QUEST. If the pregnant woman was then determined to be ineligible, she would be disenrolled, and the department would reimburse the respective health plans for medical care provided during the months in which the pregnant woman was enrolled.

Expedited application processing

The Legislature was poised to adopt House Bill No. 122, Senate Draft 2, but deferred action at the request of the Department of Human Services.

In lieu of presumptive eligibility, the department proposed an expedited application process for pregnant women. Under this proposal, an application for medical assistance would be simplified and processed within five business days. The Legislature agreed, and the department implemented an expedited process in January 2004.

The department created a form entitled, "For Children and Pregnant Women Only," exclusively for this expedited process. The new form is dubbed the "pinkie" for the pink paper on which it is printed. The form and intake process eliminated previous requirements the department deemed to be barriers to timely eligibility determination. For example, an applicant is no longer required to provide proof of pregnancy, and her assets are not considered in determining eligibility. The new form also provides for a self-declaration of pregnancy and income, and all pregnant women who walk into a department office are granted an immediate interview. The Med-QUEST Division also began accepting faxed applications and electronic signatures. With the streamlined application process, the department established an internal benchmark: processing 95 percent of applications from pregnant women within five business days.

A pregnant woman seeking general financial assistance, including medical coverage for her pregnancy, must fill out a more comprehensive form entitled, "Medical Assistance Application." The medical portion of the application is expedited in the same manner as the "pinkie" form. Notwithstanding the internal benchmark, current administrative rules allow 45 days for the department to process applications, including "pinkie" forms.

Despite the department's efforts at expediting the application process, advocacy groups and some medical practitioners have expressed concerns about the adequacy of these efforts to improve timely access to prenatal care. As a result, the Legislature requested an audit of the program.

Med-QUEST Division

The Med-QUEST Division provides overall management of the department's medical assistance programs. These programs are designed to provide medical services to eligible individuals and families through either the Medicaid fee-for-service program or the QUEST program.

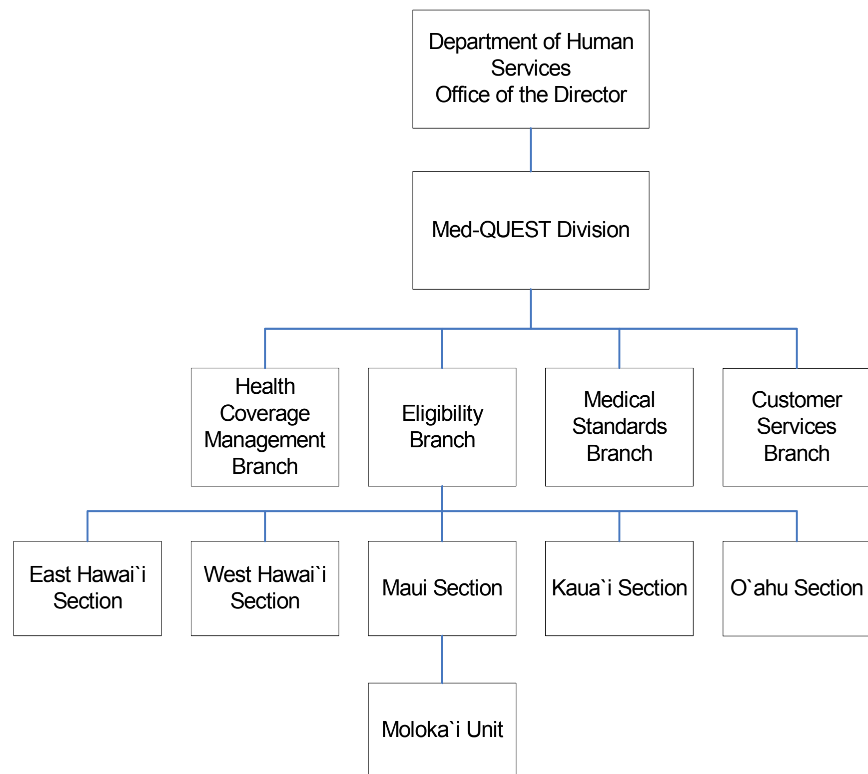
Organizational profile

The division's administration reports to the director of human services and is responsible for the plans, policies, regulations, and procedures of the medical assistance programs. Division administration is also responsible for organizing, directing, coordinating, evaluating, and

maintaining an organization that will ensure accomplishment of the division's objectives. The division is organized into four offices and four branches.

The Eligibility Branch, which includes neighbor island sections, administers the statewide program for eligibility determination related to medical assistance programs and is charged with meeting the department's expedited application processing standard for pregnant women. Exhibit 1.2 displays the Eligibility Branch's organization.

Exhibit 1.2
Department of Human Services, Med-QUEST Division • Eligibility Branch Organizational Chart



Source: Department of Human Services

Funding

The federal government and the states share responsibility for financing Medicaid. The federal government matches state spending on an open-ended basis for the services Medicaid covers. The federal matching rate, known as the federal medical assistance percentage (FMAP), varies by state and currently ranges from 50 percent to 77 percent, and is based on state per capita income.

In FY2002-03, the department enrolled 36,329 individuals into the Medicaid fee-for-service program, with the State paying its share of a little over $214.2 million and the federal government paying $294.3 million. The QUEST program enrolled 137,602 individuals during the same time period at a cost of $105.7 million to the State and $161.7 million to the federal government. Exhibit 1.3 displays the number of participants, and federal and state expenditures, for the Medicaid and QUEST programs for FYs 2002 and 2003.

Exhibit 1.3
Medicaid and QUEST Program Enrollment and Expenditures FY2001-02 and FY2002-03

Medicaid Program

Year	Enrollees	Federal	State
FY2001-02	35,357	$259,483,108	$190,861,101
FY2002-03	36,329	$294,315,369	$214,228,403

QUEST Program

Year	Enrollees	Federal	State
FY2001-02	129,953	$127,575,775	$106,933,713
FY2002-03	137,602	$161,712,173	$105,656,596

Source: Department of Human Services

Objectives

The objectives of the audit were to:

1. Assess whether the Department of Human Services' Med-QUEST Division is meeting the five-day time frame for processing applications from pregnant women for Medicaid or QUEST enrollment and subsequent initiation of prenatal care.

2. Determine whether presumptive eligibility will result in more timely access and utilization of care when compared to the current expedited application process.

3. Make recommendations as appropriate.

Scope and Methodology

Our audit focused on whether the Med-QUEST Division is meeting its benchmark to process 95 percent of applications from pregnant women within five business days. As part of our analysis, we reviewed and tested case file applications from pregnant women on O`ahu and Maui to determine processing time and compliance with the five-day standard. In addition, we reviewed division policies and procedures, financial and personnel data, and all applicable federal and state laws including the Hawai`i administrative rules. We also interviewed division staff and supervisors on all islands, staff from various federally qualified health centers on O`ahu, Maui, and Hawai`i, the federal Pacific Area, representative of the Centers for Medicare and Medicaid Services of the Department of Health & Human Services, and numerous advocates assisting pregnant women.

To determine if presumptive eligibility would result in more timely access and utilization of care in comparison to the current expedited application process, and as required by SCR 54, we surveyed 655 public and private funded medical providers associated with prenatal care (obstetrician-gynecologists, general family practitioners, and pediatricians). The survey form captured practitioner views on the current expedited application process, the adequacy of the five-day timeframe, their opinions on presumptive eligibility, and their perception of any other barriers to prenatal care. We also reviewed local and national studies regarding access to prenatal care, medical insurance, and the effects of prenatal care on birth outcomes. Additionally, we compared the current expedited application process with presumptive eligibility through a cost analysis and a review of federal guidelines on presumptive eligibility.

We conducted this audit from June 2004 through October 2004 according to generally accepted government auditing standards.

Chapter 2

The Department Does Not Meet Its Own Standard

In January 2004, the Department of Human Services began an expedited application process for pregnant women seeking medical assistance. As part of this initiative, the department promised to process 95 percent of these applications within five business days. Our review of the department's performance under this standard revealed that the department fell short, despite improving the application process. Inconsistent interpretation and application of the processing standard, flawed data collection, lack of a non-compliance penalty, and less than a year's experience with the initiative contributed to the department's failing to meet its aspirational goal. However, the alternative of presumptive eligibility would provide little additional benefit. Reduced federal requirements and streamlining efforts by the department make presumptive eligibility unnecessary. In fact, presumptive eligibility could become a barrier to early prenatal care and cost the State more money. Ultimately, the department needs additional time to make improvements to the expedited application process before rushing into potentially costly alternatives.

Summary of Findings

1. The department's Med-QUEST Division has not consistently met its five-day expedited processing standard.

2. Presumptive eligibility is unlikely to yield earlier access and earlier prenatal care as compared to the current expedited application process.

The Med-QUEST Division Does Not Consistently Process 95 Percent of Applications Within Five Business Days

The Department of Human Services claims that it processes 95 percent of applications from pregnant women within five business days. In making this claim, the department relies on statistics maintained by its Med-QUEST Division. However, in a review of applications filed with the Med-QUEST Division, we found that 71 percent of O`ahu applications were processed within five days, while Maui processed 100 percent of its applications within five days. We also found that the Med-QUEST Division does not apply the five-day standard uniformly among its units and that the statistics it relies on are flawed. In addition, the agency rules lack any non-compliance penalty for the division, providing no administrative incentive to the process. Processing times for other eligibility groups may also be adversely impacted by the expedited

application processing for pregnant women. Despite the department's shortcomings, however, it has made improvements in processing applications from pregnant women.

Expedited process aims to determine eligibility within five business days

The Med-QUEST Division operates eligibility units on all islands. The Big Island is served separately by a unit in East Hawai`i and another in West Hawai`i. O`ahu's Med-QUEST offices handle over 60 percent of all applications from pregnant women statewide. For example, between January and June 2004, the O`ahu offices processed 1,201 applications of the statewide total of 1,977. The island-by-island breakdown is noted in Exhibit 2.1.

Exhibit 2.1
Total Med-QUEST Applications from Pregnant Women as Recorded in the Hawaii Automated Welfare Information (HAWI) System for the Period January 2004 to June 2004

Island	No. of applications filed	Percent of applications filed by pregnant women
O`ahu	1,201	60.7%
Maui	254	12.8%
West Hawai`i (Kona)	198	10.0%
East Hawai`i (Hilo)	184	9.3%
Kaua`i	130	6.6%
Moloka`i	6	0.3%
Lana`i	4	0.2%
TOTAL	1,977	99.9%

* Figures do not total 100 percent due to rounding.

Source: Department of Human Services

Pregnant women can file applications for medical assistance with three agencies: a Med-QUEST Division office (MQD); a Benefits, Employment and Support Services Division office (BESSD); or a federally qualified health center (FQHC). Generally, BESSD offices process applications for all financial assistance programs and may process medical assistance applications in some instances. However, division policies and procedures require BESSD to forward applications to the Med-QUEST Division for expedited processing if a pregnant

woman is seeking medical assistance. An FQHC is an outreach facility staffed with an eligibility worker, paid for with both state and federal funds, who can accept applications for a preliminary review. However, FQHC eligibility workers are not authorized to approve applications; applications must be sent to a Med-QUEST office for approval. If an application filed at either a BESSD office or an FQHC is ultimately approved, the Med-QUEST Division will establish benefits retroactive to the date the application was filed at the respective facility.

The five-day process begins when the Med-QUEST Division receives a completed application and ends five business days thereafter. If an application is incomplete, an eligibility worker will contact the applicant for the needed information. The applicant will have up to ten days to provide the information. The five-day standard applies only when all required information is received from the applicant. When an incomplete application is filed, processing may take longer than five days because of the waiting period for information from the applicant.

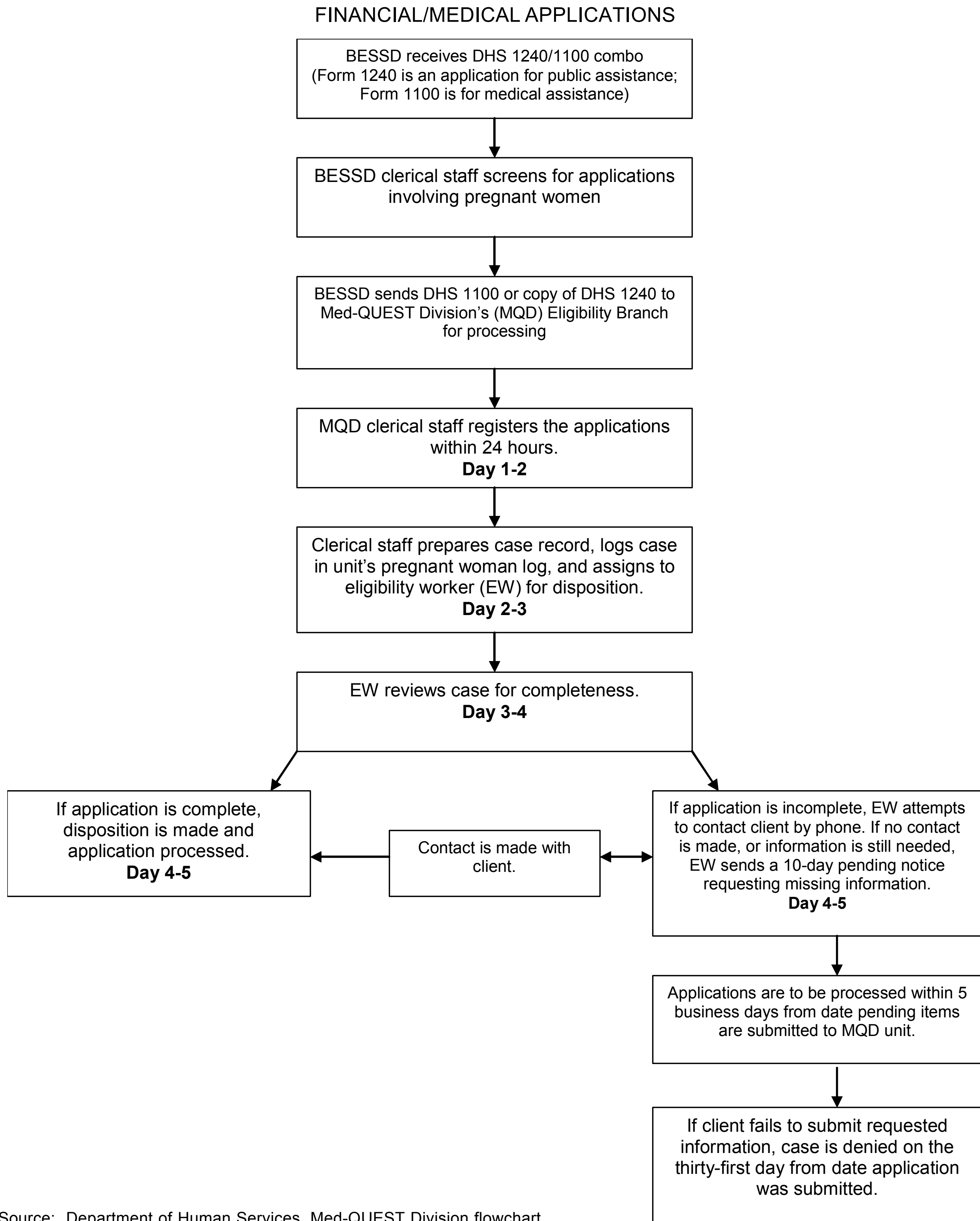
Exhibit 2.2 illustrates the processing of an application received by a BESSD office. Exhibit 2.3 illustrates the processing of an application received by a Med-QUEST office or transmitted to a Med-QUEST office by an FQHC.

The department claims compliance with the five-day standard despite statistics that indicate otherwise

According to testimony provided by the department to the Legislature regarding SCR 54, the department processed 97 percent of "pinkie" applications within five business days during February 2004. This achievement exceeded the department's promise to process 95 percent of applications within five business days. In addition, the department's director indicated to us that as of June 2004, the department had achieved over 95 percent timely application processing, with most applications receiving approval within 48 hours. The 14 unit supervisors and staff of the Med-QUEST Division that we interviewed also unanimously agreed that the division was meeting this standard.

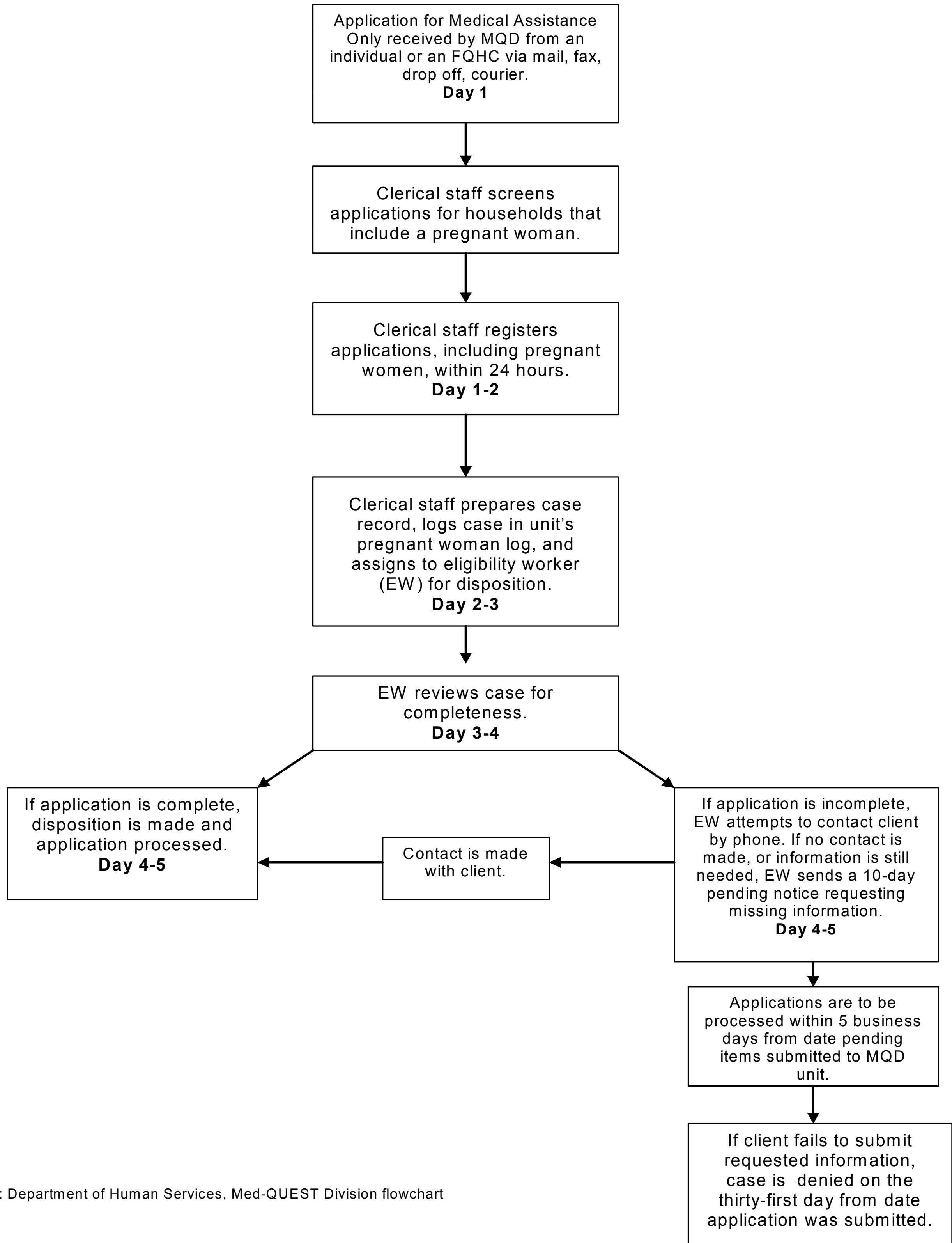
According to statistics kept by the Med-QUEST Division for the period of January 2004 through June 2004, the agency achieved an overall processing rate of 95 percent for applications from pregnant women within five business days. However, this overall figure conceals the processing rates of individual islands, some of which failed to consistently meet the standard. Specifically, units on O`ahu and Kaua`i fell short of the standard, while East Hawai`i, West Hawai`i, and Maui met the standard. Exhibit 2.4 illustrates how units on each island fared in complying with the expedited application standard.

Exhibit 2.2
Process Flowchart for Applications Filed at a Benefits, Employment and Support Services Division (BESSD) Office



Source: Department of Human Services, Med-QUEST Division flowchart

Exhibit 2.3
Process Flowchart for Applications Filed with Med-QUEST Division (MQD) or a Federally Qualified Health Center (FQHC)



Source: Department of Human Services, Med-QUEST Division flowchart

Exhibit 2.4
Statewide Statistics for Processing Applications from Pregnant Women
January – June 2004

E. Hawai`i	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Total/Avg.
Total applications received	30	20	26	42	21	35	174
No. of applications processed within 5 days	30	19	25	40	21	34	169
Percent processed within 5 days	100.0%	95.0%	96.2%	95.2%	100.0%	97.1%	97.1%
W. Hawai`i	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	
Total applications received	46	32	36	30	100	34	278
No. of applications processed within 5 days	37	32	36	30	100	34	269
Percent processed within 5 days	80.4%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%
Kaua`i	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	
Total applications received	29	14	34	19	26	24	146
No. of applications processed within 5 days	28	13	31	19	22	20	133
Percent processed within 5 days	96.6%	92.9%	91.2%	100.0%	84.6%	83.3%	91.1%
O`ahu	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	
Total applications received	232	189	188	259	275	255	1398
No. of applications processed within 5 days	209	183	152	250	269	247	1310
Percent processed within 5 days	90.1%	96.8%	80.9%	96.5%	97.8%	96.9%	93.7%
Maui *	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	
Total applications received	67	58	61	59	52	54	351
No. of applications processed within 5 days	62	56	60	57	52	54	341
Percent processed within 5 days	92.5%	96.6%	98.4%	96.6%	100.0%	100.0%	97.2%
Statewide	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	
Total applications received	404	313	345	409	407	402	2280
No. of applications processed within 5 days	366	303	304	396	397	389	2155
Percent processed within 5 days	90.6%	96.8%	88.1%	96.8%	97.5%	96.8%	94.5%

* Statistics for Moloka`i and Lana`i are included in the Maui count

Source: Department of Human Services

Our review shows a different result

In assessing the Med-QUEST Division's performance against its processing standard, we reviewed statistically valid samples of applications filed on O`ahu and Maui between January 1, 2004, and June 30, 2004. These islands were selected for testing because they processed the most applications in the State. O`ahu has the greater number of applications overall, and Maui has the highest number of applicants among all the neighbor island units. We found that only 71 percent of the O`ahu applications sampled were processed in a timely manner, while Maui complied 100 percent with the standard.

O`ahu sample achieved a 71 percent compliance rate

Our office reviewed 76 of the 1,201 applications filed by pregnant women on O`ahu between January 1, 2004, and June 30, 2004. The sample of 76 was determined by applying a confidence level factor of 95 percent and a confidence interval of 5 percent to the 1,201 applications.

We calculated the number of days by looking for the date the application was received, time-stamped at the Med-QUEST Division, up to and including the date an eligibility determination was made. If an application was incomplete we calculated the number of days based upon the date that complete information was received by the Med-QUEST division. In calculating the number of days, we excluded weekends and holidays. In other words, the standard defined by the department was the same standard used in our review. We reviewed both the application file and the data stored in the Hawai`i Automated Welfare Information (HAWI) system, which is the computer database used by the department for intake, eligibility determination, case management, and other functions.

Of the 76 randomly selected O`ahu case files we reviewed, 11 were deemed invalid because the applicant was already receiving medical assistance. This "duplicate" application occurs when a woman is applying for other assistance while pregnant. For example, a woman who is already receiving medical coverage from the State may apply for medical assistance for one of her dependent children. If she happens to be pregnant at the time of application and indicates on her application that she is pregnant, her application is flagged for expedited processing—even though she is not applying for medical assistance for herself. The HAWI system does not distinguish applications of pregnant women filing for medical assistance for themselves from those she may be filing for others.

We found that of the 65 cases reviewed (76 in the sample, less the 11 that did not require processing), only 43 applications, or 66 percent, were processed within five business days. The average number of days it took

to process the 65 applications was 6.8 days. The processing time ranged from one to 28 days.

Of the 65 applications reviewed, 22 took longer than five days to process. The average processing time for the 22 delayed applications was 15.3 days. Exhibit 2.5 reveals that both BESSD and Med-QUEST offices were responsible for the delays, with BESSD experiencing the longer average delay—18.4 days.

Exhibit 2.5
Delayed O`ahu Applications

Agency	No. of delays	Avg. length of delay
BESSD	7	18.4 days
Med-QUEST Div.	15	13.8 days
Total	22	15.3 days

BESSD – Benefits, Employment, and Support Services Division

Source: Office of the Auditor

When we include the 11 "duplicate" cases and assume that these applications were "processed" within five business days, the O`ahu Med-QUEST Division offices processed only 71 percent within five days. This is still short of the 95 percent rate established by the department.

Extrapolating from our review, we estimate that 29 to 33 percent of pregnant women on O`ahu who applied for medical assistance between January and June 2004 may not have received an eligibility determination within five days. We note, however, that current administrative rules allow the department up to 45 days to make an eligibility determination.

Maui sample achieved a 100 percent compliance rate

Our office reviewed 61 of the 254 Maui applications filed by pregnant women on Maui between January 1, 2004, and June 30, 2004. The sample of 61 was determined by applying a confidence level factor of 95 percent and a confidence interval of 5 percent to the 254 applications.

As before, we calculated the number of days by looking for the date the application was received, time-stamped at the Med-QUEST Division, up to and including the date an eligibility determination was made. If an application was incomplete, we calculated the number of days based

upon when complete information was received by the Med-QUEST division. In calculating the number of days, we excluded weekends and holidays. In other words, the standard defined by the department was the same standard used in our review. We reviewed both the application file and the data stored in the HAWI system.

Of the 61 randomly selected cases we reviewed, 12 were deemed invalid because the applicant was already receiving medical assistance. This "duplicate" application occurs when a woman is applying for different benefits. In another instance, an application could not be located in the application file.

We found that all 48 valid cases (61 in the sample, less 12 that did not require processing and one that could not be located) tested were processed within five business days. The average number of days it took to process the 48 test applications was 2.1 days.

When we include the 12 "duplicate" applications and the one application that could not be located, and assume these applications were processed within five business days, the Maui office would be at 100 percent. Although we could also assume that the 13 applications were not processed within five business days, we do not believe this to be the case, based on interviews with Maui staff and a representative from the Community Clinic of Maui, and the HAWI report for all applications filed on Maui.

Pregnant women on Maui who applied for medical assistance from the State between January and June 2004 almost certainly received an eligibility determination within five days. Those who were determined eligible were able to access prenatal care in a timely manner.

It may be too early to draw any definitive conclusions about the efficacy of the expedited application process

We note that expedited processing for pregnant women was established only in January 2004. The department began formally tracking its processing times beginning in February 2004. We believe it may be too early to draw any definitive conclusions about the effectiveness of the department's standard and process. A full 12 months of data would provide a better picture of the department's ability to meet its standard and to address some processing problems, as we discuss next.

The O`ahu Benefit, Employment and Support Services Division failed to consistently transfer applications from pregnant women to the Med-QUEST Division

The Benefit, Employment and Support Services Division (BESSD) is processing applications from pregnant women, contrary to division policies and procedures. The BESSD provides a continuum of services for its clients with monthly benefits to assist them with such essentials as food, shelter, and child care, as well as employment support and work-training. Programs administered by BESSD include general assistance, food stamps, aid to the aged, blind, and disabled, and employment and training. In some instances the BESSD office is authorized to process medical assistance applications for the aged, blind, and disabled group and those receiving supplemental security income. However, if BESSD receives an application for medical assistance, its staff is expected to identify applications from pregnant women and forward the applications to the Med-QUEST Division for expedited processing.

In our test sample of O`ahu applications, we found that BESSD was responsible for seven of 22 delayed applications, averaging 18.4 days to process applications from pregnant women. In three of the seven delayed cases, BESSD staff processed the medical assistance application and did not forward them to Med-QUEST for expedited processing. The three applications processed by BESSD took 10, 14, and 27 days to process, respectively.

In summary, many applications for medical assistance from pregnant women were processed by BESSD contrary to division policies and procedures. Had BESSD staff followed department policies and procedures, the delays may have been avoided, and it is likely that applicants would have had earlier access to prenatal care.

The Med-QUEST Division does not apply the five-day standard uniformly among its units

According to the department's standard, a pregnant woman's completed medical assistance application must be processed within five business days from the date it is received at a Med-QUEST office. We found that division staff had different interpretations of the standard and that applications taken in by federally qualified health centers were subjected to varying standards.

Staff and supervisors have different interpretations of the processing standard

We interviewed 14 Med-QUEST unit supervisors and staff on all islands to determine how they applied the division's standard for processing applications from pregnant women. We found that only five of the 14 Med-QUEST staff interpreted and applied the division's policy correctly.

Seven of the staff members interviewed started the five-day timeframe from the date time-stamped at BESSD or an FQHC. One staff member started counting the five days one day after the application is received at

the Med-QUEST office. Four staff members calculated the timeframe using calendar days instead of business days. The department's failure to clearly define and instruct the staff results in inconsistent and incorrect performance. Moreover, the department may be creating a perception of unequal treatment among pregnant women seeking medical assistance.

Applications submitted by federally qualified health centers are subject to varying standards

The division recognizes ten federally qualified health centers (FQHC) in Hawai`i. These centers receive applications from pregnant women and forward them to the Med-QUEST Division for processing.   Each center has a case worker who reviews applications for completeness and general compliance. Although the division will begin the five-day processing timeframe from the date the application is received at a Med-QUEST office, medical coverage for those deemed eligible will be applied retroactively to the date the applicant applied for medical assistance at the FQHC.

We interviewed staff from six FQHCs on O`ahu, Maui, and the Big Island and found that only three applied a five-day timeframe consistent with the division's policies and procedures. The three centers that did not follow the division's guidelines started the five-day timeframe when the center time-stamped an application and ended the period five calendar, instead of business, days thereafter. In one instance, we found that a neighbor island FQHC had a "verbal agreement" with the local Med-QUEST office to process applications within two days.

Statistics maintained by the division are flawed

Statistics maintained by the Med-Quest Division regarding the number of applications received from pregnant women contradict the figures generated by the department's intake database. The statistics also include some applications that should be excluded from the calculations and exclude others that should be included.

Statistics maintained by division staff do not reconcile with those calculated by the division's database

The Med-QUEST Division maintains statistics on the timely processing of applications from pregnant women. Each unit supervisor of the Med-QUEST Division submits monthly statistical reports to the O`ahu section administrator for compilation. In addition to the statistics maintained by the administrator, the HAWI system generates similar ad hoc reports.

When we compared the staff and computer-generated reports, we found that there was a discrepancy of 303 applications for the period of January

2004 through June 2004. The discrepancies, most pronounced on O`ahu and Maui, were especially problematic since our testing was conducted on those two particular islands. Exhibit 2.6 compares the numbers generated by the two sources.

Exhibit 2.6
Comparison of Statistical Reports Generated by the Med-QUEST Division and the Hawai`i Automated Welfare Information System for January 2004 through June 2004

	Med-QUEST statistics	HAWI statistics	Difference between the two reports
East Hawai`i	174	184	-10
West Hawai`i	211	198	13
Kaua`i	146	130	16
O`ahu	1,398	1,201	197
Maui*	351	264	87
Total statewide	2,280	1,977	303

* Includes applications filed on Moloka`i and Lana`i

Source: Department of Human Services

Applications processed by the Benefits, Employment and Support Services Division are not included in the division's statistics

Under department policies and procedures, the Benefits, Employment and Support Services Division (BESSD) is required to transmit medical applications from pregnant women to the Med-QUEST Division for expedited processing. However, during our testing, we found that BESSD units kept these applications for processing by their staff. Both the Med-QUEST Division administrator and the O`ahu section administrator acknowledged that BESSD units do not provide the Med-QUEST Division with statistics on the number of applications from pregnant women processed by BESSD. The omission of applications processed by BESSD in Med-QUEST Division reports skews the statistics in favor of the department and fails to accurately portray the division's performance.

Possible inclusion of inappropriate applications may skew department figures

During our testing of application files on O`ahu and Maui, we noted that 22 applications in our test sample were "duplicate" applications–that is,

applications submitted by pregnant women already receiving medical benefits. According to unit supervisors on O`ahu and Maui, the "duplicate" applications are omitted from the monthly statistics reported to the administrator. If the "duplicate" applications were indeed omitted from the units' statistics, we would expect the division's numbers to be significantly less than the numbers reported by the HAWI system, since the HAWI system does not distinguish between pregnant women filing for medical assistance for themselves and those filing for others. Nonetheless, as Exhibit 2.6 indicates, the division's figures are only lower at one unit in the State than those from HAWI.

When we brought this discrepancy to the attention of the division, neither the division administrator nor the O`ahu section administrator could explain the differences. Absent any explanation, applications from pregnant women already receiving medical benefits, thereby requiring no further processing by Med-QUEST Division staff, are very likely being included in the department's statistics. According to an eligibility worker, all applications that indicate a pregnancy are logged by eligibility workers, even if the client is already receiving medical benefits. If these applications are ultimately included in the statistics reported by supervisors, the overall results could be skewed, since "processing" these applications is likely to take only one day.

The conflicting data, exclusion of some applications, and possible inclusion of inappropriate applications in statistical counts leave little confidence in the information reported by the department. The department's use of skewed figures and inaccurate calculations inhibits the department's ability to determine if it is, in fact, processing 95 percent of applications from pregnant women within five business days and lends little credibility to its public claims of compliance.

Hawai`i administrative rules lack any penalty for non-compliance with the five-day processing standard

According to Section 17-1711-13, Hawai`i Administrative Rules, eligibility for medical assistance shall be determined within 45 days from the date of application, including applications from pregnant women. The rules also specify that a delay beyond the 45 days attributable to the department, shall not result in the withholding of medical assistance from the applicant. A presumption of medical eligibility shall be made on the forty-sixth day.

The expedited processing for pregnant women, on the other hand, is an internal standard established by the director. This standard deviates from the 45 days under administrative rules. Furthermore, the internal standard established by the director does not address non-compliance. This omission leaves the division without an administrative tool to enforce the expedited five-day standard for pregnant women and creates no incentive for division workers to comply. We also note that since the

expedited five-day standard is not captured in an administrative rule, the department may, at any time, rescind the internal policy without public or legislative input.

Processing times for other eligibility groups may have been impacted by expedited application processing

The Med-QUEST Division maintains various application processing deadlines, ranging from two days to 60 days, depending on the client group served. Some deadlines are established by administrative rule; others, as in the case of applications from pregnant women, are based on internal guidelines. Exhibit 2.7 describes the various application processing deadlines established by the division.

Exhibit 2.7
Application Processing Deadlines - Med-QUEST Division

2 Days [1]	5 Days [2]	45 Days [3]	60 Days [4]
Medical emergency	• Foster care • Nursing home placement • Pregnant women • Children only	All individuals applying for medical assistance NOT based on a disability	All individuals applying for medical assistance based on a disability

Source: Department of Human Services

[1] Established in Hawai`i Administrative Rules §17-1711-8
[2] Federal regulations do not require the State to process these applications within five days. However, the director of human services has mandated expedited application processing for these groups.
[3] Established in Hawai`i Administrative Rules §17-1711-13(e)(2)
[4] Established in Hawai`i Administrative Rules §17-1711-13(e)(1)

We intended to review statistical reports and case application files for groups other than pregnant women, comparing the application processing times for the periods of January to June 2003 and January to June 2004. However, the Med-QUEST Division advised us that it does not maintain application processing time statistics for other groups. We were told that retrieving the information from a database of more than 84,000 application files would be technically cumbersome and that generating statistical information would likely involve manually separating more than 84,000 application case files by code, tallying the number of days to process each application, and calculating an average. We turned to other relevant information for our assessment.

We found that increased numbers of pregnant women applying for Medicaid assistance, staff shortages, and the expedited processing of

applications for pregnant women and others, may have an adverse impact on non-expedited groups.

The department has enrolled more pregnant women

The Med-QUEST Division enrolled more pregnant women in the first six months of 2004 than in the same time period in 2003. As illustrated in Exhibit 2.8, the division processed 503 more applications from pregnant women in the first six months of 2004 than during the same period in 2003. This was an increase of 28.3 percent.

Exhibit 2.8
Number of Medical Assistance Applications Received from Pregnant Women by the Med-QUEST Division from January-June 2003 v. January-June 2004

	2003	2004
JAN	247	404
FEB	272	313
MAR	335	345
APR	316	409
MAY	307	407
JUN	300	402
Total	**1,777**	**2,280**

Source: Department of Human Services

Staff perceive a shortage of workers

As of July 2004, the Med-QUEST Division employed a staff of 112 eligibility workers to process medical assistance applications statewide. O`ahu division offices had 70 workers, the Big Island had 22, Maui had 11, Kaua`i had seven, and Moloka`i and Lana`i each had one worker. There were two position vacancies on O`ahu, while no other office reported any vacancies. According to the division administrator, the position counts in the division have not increased over the past two years.

In interviews with division staff and supervisors, 13 of 14 employees asserted that the division needs to hire additional staff. One supervisor commented that, although self-declaration of information on medical applications and passive renewals of on-going cases have streamlined application processing, the units are receiving more applications and managing higher caseloads. A supervisor of a neighbor island unit noted that current eligibility workers process approximately five applications

that current eligibility workers process approximately five applications per day, in addition to managing between 500 and 600 on-going client cases. She reported that the work is being done, but could be improved with additional staffing.

In addition to the static workforce in the face of an increasing workload, staff members also felt that a high turnover of clerks and eligibility workers within the division units exacerbated the staffing problem. A unit supervisor also reported that some positions in the units are "limited term" positions that are routinely vacated as the incumbent seeks a permanent position elsewhere.

Application processing of other eligibility groups must defer to expedited applications

According to division staff, in order to meet the department-imposed expedited processing standard, unit workers must "drop" whatever they are doing to process an application from a pregnant woman or other client highlighted for special handling, such as applicants for emergency or foster care. Some units have dedicated staff to process applications from pregnant women. Nonetheless, this arrangement takes workers away from processing other applications, potentially impacting processing times of other groups.

The overall increased enrollment of pregnant women into the system, the perceived staff shortage, and the "drop everything" policy to process expedited applications, are likely impacting the processing times of other groups, although we could not quantify the impact. If processing times for other groups are adversely impacted, then the well-intended policy of expediting certain groups may result in delaying services for others.

The department has made improvements in processing applications from pregnant women

Despite questionable statistics regarding the Med-QUEST Division's compliance with its five-day processing standard, pregnant women advocacy groups, provider groups, community health centers, and government monitoring agencies perceive improvements in the application process. We spoke with representatives from various advocacy groups, provider groups, community health centers, and a government monitoring agency to gauge their views on the department's expedited application process. The groups included the American College of Obstetricians and Gynecologists; Community Clinic of Maui; Hawai`i Covering Kids; Hawai`i Primary Care Association; Healthy Mothers, Healthy Babies; Kalihi-Palama Health Center; March of Dimes, Hawai`i; Department of Health, Maternal and Child Health Division; Mothers Care; Wai`anae Coast Comprehensive Health Center; and the U.S. Centers for Medicare and Medicaid Services.

We learned that representatives from all 11 groups perceived the department's expedited application process as an improvement over the prior system. Additionally, only one individual evaluated the current process as inadequate; six others rated the process as adequate. A representative from an advocacy group observed, "The application is easier and the department is processing them faster." A representative from a community health clinic commented, "The amount of documentation required has been reduced and the application form is simplified. It saves a lot of time."

The positive perceptions of the department's expedited application process indicate that the department has made improvements in the eyes of stakeholders, despite falling short of its standard to process 95 percent of applications from pregnant women within five business days. We believe the department has made good progress in its effort to reduce barriers to care and should continue future improvements to meet its standard.

The Current Expedited Process Is Probably Better Than Presumptive Eligibility

National and local advocacy groups promote early prenatal care as a means to ensure positive birth outcomes. In an effort to ensure early access to care, 32 states confer presumptive eligibility to pregnant women applying for Medicaid. Instead of presumptive eligibility, Hawai`i utilizes an expedited application processing program to achieve the same goal. We found that like the rest of the country, Hawai`i continues to struggle with an increase in the number of low-birthweight babies, inconsistent utilization of prenatal care by pregnant women, and a lack of insurance coverage for prenatal care. To assess the need for presumptive eligibility, we reviewed medical studies and surveyed Hawai`i's medical practitioners. The conclusions are mixed regarding the need for presumptive eligibility. We also found that changes in federal requirements render presumptive eligibility unnecessary and that presumptive eligibility could, ironically, become a barrier to early access to prenatal care. And finally, the cost to implement presumptive eligibility could be prohibitive.

Local and national studies laud early prenatal care, while medical research findings remain inconclusive

Presumptive eligibility is intended to facilitate early access to prenatal care. Both local and national studies espouse the positive impact of early prenatal care on birth outcomes. Early intervention is viewed as a key element in addressing Hawai`i's continued rise in low-birthweight babies. However, medical research has found the connection between early prenatal care and positive birth outcomes to be inconclusive. A local study also identified other barriers, besides insurance status, as key deterrents to accessing prenatal care.

Advocacy groups and public organizations cite trends favoring early prenatal care intervention

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists have defined prenatal care as "a comprehensive ante partum care program that involves a coordinated approach to medical care and psychological support that optimally begins before conception and extends throughout the ante partum period." The major goals of prenatal care are to define the health status of the mother and fetus, to determine the gestational age of the fetus, and to initiate a plan for continuing obstetrical care.

Reducing infant mortality and problems associated with low birthweight through prenatal care is much less expensive than using advanced technologies to care for premature babies. Good prenatal care, which leads to healthier babies and fewer premature deliveries, has been a fundamental part of the U.S. health care system since the early 1900s. Prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for women and infants. While the number of prenatal visits is high, with some women making as many as 17 visits, only 75 percent of pregnant women in the United States receive prenatal care in the first trimester. For example, there were more than 41 million prenatal visits in 1998, with a median of 12.4 visits per pregnancy.

According to the Centers for Disease Control, the leading causes of infant death are congenital problems, pre-term delivery or low birthweight, sudden infant death syndrome, problems related to complications of pregnancy, and respiratory distress syndrome. Technology, increased access to prenatal care, and public education have contributed to lowering infant mortality rate. Research has found that prenatal care is more likely to be effective if women begin receiving care early in pregnancy. Since 1990, the proportion of infants whose mothers entered prenatal care in their first trimester increased 8.8 percent, from 76 percent to 83 percent. This increase is likely due, in part, to increased access to Medicaid coverage for pregnancy-related services and improved outreach by Medicaid programs.

Hawai`i has experienced a rise in low-birthweight babies

A low-birthweight baby is defined as a baby weighing less than 2,500 grams, or 5.5 pounds, at birth. Low birthweight is associated with long-term problems such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities. Some children with these problems will require years, even a lifetime, of help to maintain quality of life.

Between 2001 and 2003, Hawai`i experienced a 12.3 percent increase in the number of low-birthweight babies, as shown in Exhibit 2.9. According to Department of Health statistics, women who sought prenatal care in their first trimester experienced an increase of only 7.2 percent in the number of low-birthweight babies between 2001 and 2003. Yet those women who first sought prenatal care in their second or third trimesters had increases of 43.1 percent and 34.6 percent, respectively, in the number of low-birthweight babies.

Exhibit 2.9
Number of Low-Birthweight Babies Born and Time of Prenatal Care Access, 2001-2003

TRIMESTER OF FIRST PRENATAL CARE VISIT	LOW-BIRTHWEIGHT BABIES			
	2001	2002	2003	% change 01-03
None	14	24	28	100.0%
1st Trimester	1,138	1,168	1,220	7.2%
2nd Trimester	144	154	206	43.1%
3rd Trimester	26	43	35	34.6%
Unknown	64	60	68	6.3%
Total	1,386	1,449	1,557	12.3%

Source: Department of Health - Office of Health Status Monitoring

Exhibit 2.10 illustrates the month in a woman's pregnancy in which she sought prenatal care in Hawai`i during 2001 through 2003. The statistics reveal a mixed bag of results. Generally, the increase in the number of women seeking prenatal care is encouraging. However, some of the largest increases in initial visits were found in the sixth, eighth, and ninth months of pregnancy, which may affect the efficacy of prenatal care.

Hawai`i continues to experience increased numbers of low-birthweight babies and women who delay prenatal care. These figures indicate the State may still be paying high medical costs for low-birthweight babies and that there are other barriers to prenatal care.

Local study examined and identified insurance status as only one barrier to early prenatal care

A team of researchers from the Hawai`i State Department of Health conducted a study to examine whether insurance status or other barriers cause delays in accessing prenatal care. They used a set of related questions from the Pregnancy Risk Assessment Monitoring System (PRAMS) 2000 to 2001 data set[1]. The hypothesis of the study was that

Exhibit 2.10
2001-2003 Resident Live Births by Month Prenatal Care Began

MONTH PRENATAL CARE BEGAN	YEAR OF BIRTH			
	2001	2002	2003	% change 01-03
None	70	114	103	47.1%
1	4,835	5,619	5,381	11.3%
2	6,306	5,888	6,168	-2.2%
3	2,849	2,800	2,970	4.2%
4	1,051	1,101	1,307	24.4%
5	573	625	639	11.5%
6	371	416	499	34.5%
7	265	240	253	-4.5%
8	148	155	187	26.4%
9	65	64	82	26.2%
Unknown	510	424	469	-8.0%
Total	17,043	17,446	18,058	6.0%

Source: Department of Health, Office of Health Status Monitoring

having no insurance before pregnancy delays a woman's entry into prenatal care. Appendix A illustrates the socioeconomic characteristics of the study population.

The department's research team found that women who have insurance prior to pregnancy are more likely to get earlier prenatal care and thus have a greater chance of receiving preventive care and education to prevent or minimize maternal and infant morbidity. Appendix B illustrates the distribution of pregnant women's access to prenatal care by insurance status. Although a number of barriers may impede early entry into care, lack of insurance is one of those most commonly mentioned by women who enter care late and remains a significant barrier after controlling for other sociodemographic factors. This finding echoes those of several national studies.

Lack of insurance is not the major or only barrier to access to prenatal care. However, it is an important barrier. Other barriers include not knowing about the pregnancy or not obtaining an appointment for prenatal care. See Appendix C for the barriers most commonly cited by pregnant women.

For nearly half of the women surveyed, not knowing they were pregnant was a barrier to accessing early prenatal care—echoing a finding suggested by national studies. However, among women with incomes below the poverty level, the next most common barrier was not enough money or insurance. For women with incomes between 101 and 185 percent of the federal poverty level, which is the group served by the

Hawai`i QUEST program, the second most commonly cited barrier to prenatal care was the unavailability of a doctor's appointment. The lack of money or insurance was the third most commonly cited barrier. Appendix D displays the barriers to care, adjusted by income level.

The team's report identified strategies for reducing barriers to prenatal care, including presumptive eligibility under Medicaid, which effectively extends insurance coverage for the first prenatal visit. The research team saw a strong need for outreach programs to educate women about planned pregnancy, presumptive eligibility, and expedited eligibility. Other strategies for reducing barriers included educating women about the signs and symptoms of pregnancy, increasing the availability of insurance for prenatal and delivery services through the State, and improving geographic accessibility of providers. The report's finding, from the pregnant women's perspective, differs from our survey of medical providers. Our survey respondents perceived the lack of insurance as the most common barrier to prenatal care.

The lack of medical insurance was a commonly cited barrier to early prenatal care for women giving birth between 2000 and 2001. We found that the number of pregnant women with insurance coverage through the Medicaid program increased from 5,647 in 2001 to 6,510 in 2003. Furthermore, the department has initiated an expedited application process to speed enrollment of qualified pregnant women. While presumptive eligibility would ensure initial insurance coverage, it does not guarantee continuous coverage. We believe that the current expedited processing addresses the lack of insurance as a barrier to care and offers women better assurance of coverage throughout pregnancy.

Obstetrics and gynecology manuals claim the connection between early prenatal care and positive birth outcomes is inconclusive

An extensive review conducted in 1995[2] could not find conclusive evidence that prenatal care improved birth outcomes. Other reviews[3] have also raised doubts about the effectiveness of prenatal care during the 1980s and 1990s. During that period, utilization of prenatal care substantially increased, but the rates of low-birthweight babies and pre-term births in the U.S. worsened.

On the other hand, a series of well-designed reports published in 1997[4] examined the effects of psychosocial interventions during the prenatal period and the first 24 months of post-natal life. A psychosocial intervention is carried out in relation to or as part of providing a healthcare service. The intervention is performed with an expectation of treating a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to

recognize reality, or ability to meet the ordinary demands of life. These studies showed that such interventions can increase birthweight, prevent preterm birth, reduce child abuse and neglect, and also reduce antisocial behavior later in life. Studies such as these suggest that the benefits and limitations of prenatal care should be measured not only in the context of immediate pregnancy outcomes, but also in the context that prenatal care can be a gateway to behavior modification that can benefit both mothers and their children. Measuring the effects of prenatal care should encompass more than counting the number of prenatal visits in relation to birth outcomes.

Another obstetrics manual[5], printed in 2003, notes that current emphasis on prenatal care stems from historic pronouncements and retrospective analyses that concluded women who receive prenatal care have less fetal, infant, and maternal morbidity and mortality. However, a conclusive scientific foundation is lacking for the content of prenatal care and the relationship of its components to good outcomes. As technology flourishes and resources dwindle, it has become increasingly important to obtain scientifically-based evidence demonstrating which components of prenatal care are clinically appropriate and cost-effective, and which deserve preferential funding. At this time the optimal content and delivery of prenatal care remain the subject of discussion and debate.

Presumptive eligibility is utilized in 32 states and territories to improve access to early prenatal care

Currently, 32 states and territories have established presumptive eligibility for pregnant women applying for Medicaid assistance (Exhibit 2.11). Hawai`i does not have a presumptive eligibility feature for pregnant women applicants.

Two examples are California and Kentucky. The California presumptive eligibility program allows qualified providers to grant immediate, temporary Medi-Cal (California's Medicaid program) coverage to low-income, pregnant patients for ambulatory prenatal care and prescription drugs for conditions related to pregnancy, pending their formal Medi-Cal application. The program is designed for women who believe they are pregnant and do not have health insurance or Medi-Cal coverage.

In November 2001, the State of Kentucky established its presumptive eligibility program to enable eligible pregnant women to receive prenatal care through Medicaid while their eligibility for full Medicaid benefits is being determined. Kentucky anticipated that by providing earlier prenatal care, it could improve maternal and newborn health outcomes and reduce the costs associated with low birthweight and neonatal morbidity. The intent of the program was to be an important step toward providing quality care for all pregnant women and the best possible start in life for all Kentucky children.

Exhibit 2.11
U.S. States and Territories Providing Presumptive Eligibility for Pregnant Women Under Medicaid

Alabama		Nebraska	■
Alaska		Nevada	
American Samoa		New Hampshire	■
Arizona		New Jersey	■
Arkansas	■	New Mexico	■
California	■	New York	■
Colorado	■	North Carolina	■
Connecticut		North Dakota	
Delaware	■	N. Mariana Islands	■
District of Columbia	■	Ohio	
Florida	■	Oklahoma	■
Georgia	■	Oregon	
Hawai`i		Pennsylvania	■
Idaho	■	Puerto Rico	
Illinois	■	Rhode Island	
Indiana		South Carolina	
Iowa	■	South Dakota	
Kansas	■	Tennessee	■
Kentucky	■	Texas	■
Louisiana	■	Utah	■
Maine	■	Vermont	
Maryland		Virgin Islands	
Massachusetts	■	Virginia	
Michigan	■	Washington	
Minnesota		West Virginia	
Mississippi		Wisconsin	■
Missouri	■	Wyoming	■
Montana	■		
TOTAL			32

Source: Maternal and Children's Health Update 2002, National Governors Association

Rationale for presumptive eligibility

The federal government implemented presumptive eligibility in the early 1990s. Related regulations were published in 1994. Previously, Medicaid requirements were cumbersome. Face-to-face interviews, medical certification confirming pregnancy, and income verification were required to determine benefit eligibility. Booming state economies during the 1990s, resulting in state budget surpluses, combined with increased outreach efforts, boosted the Medicaid program enrollment. To accommodate increased Medicaid enrollment and to keep up with eligibility determinations, states implemented presumptive eligibility to ensure that access to medical care was not hindered by the eligibility process. At the same time, Hawai`i was experiencing an economic slump, resulting in budget deficits. The State had little incentive to increase Medicaid rolls and incur additional costs. These economic conditions may have kept Hawai`i from implementing presumptive eligibility.

Today, federal Medicaid eligibility requirements have been minimized and streamlined. There is no face-to-face interview requirement, faxed applications are accepted, and people can self-declare income and pregnancy status. Given the reduced federal requirements, presumptive eligibility may not be as advantageous as it may have been in the 1990s.

Federal guidelines for presumptive eligibility

The U.S. Code establishes minimum guidelines for providing presumptive eligibility to pregnant women under Title 42, Chapter XIX, Section 1396r-1. Under presumptive eligibility, a qualified provider could determine that the family income of a pregnant woman does not exceed the applicable state level of eligibility. The presumptive eligibility period begins as soon as the qualified provider makes the initial determination and ends when the state makes an eligibility determination under the state plan or the last day of the month following the month in which the provider made the initial determination, whichever is sooner.

A qualified provider is any provider who is eligible for payments under an approved state plan, provides services of the type described, and is determined by the appropriate state agency to be capable of making determinations of eligibility. This qualified provider is responsible for:

1. notifying the appropriate state agency of the determination within five working days after the date on which the determination was made; and

2. informing the pregnant woman at the time the determination is made that she is required to apply for medical assistance under the state

plan not later than the last day of the month following the month in which the determination was made.

A pregnant woman, who is determined by a qualified provider to be presumptively eligible for medical assistance under a state plan, must apply for medical assistance no later than the last day of the month following the month in which the determination was made. For example, if a qualified provider determines on June 10th that a pregnant woman is presumptively eligible, the woman must apply with the State by July 31st.

Federal guidelines require a two-step process under a presumptive eligibility scheme. First, a qualified medical provider would make an initial determination of eligibility. Secondly, the pregnant woman would apply for permanent medical assistance through the process determined by each state. One of the negative features of presumptive eligibility is the potential loss of medical coverage. After the initial eligibility determination by a qualified provider, failure to follow through with the application for permanent eligibility exposes the pregnant woman to loss of medical coverage after the presumptive eligibility period ends. She cannot thereafter request an additional presumptive eligibility period. Federal presumptive eligibility does not cover labor and delivery services. Only pregnant women who are determined permanently eligible can receive such coverage.

Survey of medical practitioners reveals mixed views on expedited application processing, early prenatal care, and presumptive eligibility

To assess their views on the expedited application processing and the potential need for presumptive eligibility, we surveyed 655 obstetrician-gynecologists (OB-GYN), pediatricians, and family and general physicians (all three groups referred to as physicians). We received 251 completed survey forms for a return rate of 38 percent. A breakdown of our survey respondents is set forth in Exhibit 2.12. The survey form queried OB-GYNs and family and general practitioners since they are most apt to work directly with pregnant women. Pediatricians were included because they have a stake in positive birth outcomes. All of the physicians have a vested interest in ensuring quality medical care for pregnant women. Survey questions gauged the practitioners' views on the adequacy of the department's expedited application process, the acceptability of the five-day eligibility determination timeframe, their own policy on serving the uninsured or those covered by Medicaid, the need for presumptive eligibility, their willingness to participate as a qualified provider under a presumptive eligibility scheme, and barriers to early prenatal care.

Exhibit 2.12
Practitioner Survey Respondent Breakdown

	No.	Percent
Obstetrician/Gynecologist	68	27.1%
Pediatrician	85	33.9%
Family/General practitioner	79	31.5%
Other	19	7.6%
TOTAL	251	100.1%

* Figures do not total 100 percent due to rounding.

Source: Office of the Auditor survey (2004).

Practitioners are unsure if expedited application processing is adequate

We asked the survey respondents if the department's expedited application process for pregnant women was adequate in ensuring that qualified pregnant women have timely access to prenatal care. Sixty percent indicated they were not sure if the process was adequate; a total of 31 percent viewed the process as adequate; only 9 percent viewed expedited application processing as inadequate. Focusing only on practitioners who treat pregnant women, we found a higher level of positive responses: 40 percent of OB-GYNs and 44 percent of family or general practitioners felt the expedited application process was adequate.

Over half of the total practitioners responding were unsure about the adequacy of expedited application processing. More time and experience with this initiative may be needed to assess its overall effectiveness. We note, however, that the relatively low number of respondents viewing the process as inadequate is encouraging for the department.

The five-day eligibility determination period does not generally pose a medical hardship to pregnant women

We asked practitioners if the five-day period was a medically acceptable period before a pregnant woman learns whether she is eligible for medical assistance. We found that 72 percent of OB-GYNs and 77 percent of family or general practitioners felt the five-day period was acceptable. Only 40 percent of pediatricians viewed the five-day period as acceptable.

In addition to the practitioner survey, we reviewed medical journals for a medical standard for providing timely prenatal care. In *Williams Obstetrics, 17th Edition*, 1985, the guideline given to obstetricians was that even in the absence of identified pregnancy problems, all women should be given an appointment within 10 days. However, the most current edition of *Williams Obstetrics*, 21st Edition, June 2002 is less definitive, merely stating that prenatal care should be initiated as soon as there is a reasonable likelihood of pregnancy.

Based on practitioner responses, particularly those of OB-GYNs and family and general practitioners, the department's five-day expedited application process is generally not viewed as posing a medical hardship to pregnant women. One advocate's perception that the five-day period is too long is generally in contrast to the views of medical professionals responding to our survey.

Some practitioners limit or refuse Medicaid clients

According to our survey, 61 percent of OB-GYNs and 78 percent of family or general practitioners indicated they accept Medicaid clients; approximately 39 percent of OB-GYNs and 22 percent of family or general practitioners claimed to limit or refuse to accept Medicaid clients. With over one-third of OB-GYNs and nearly one-fourth of family and general practitioners responding to our survey indicating that they either limit or refuse Medicaid clients, the limited availability of medical providers to serve pregnant Medicaid clients in the community could be a barrier to prenatal care even under the current expedited application process or a presumptive eligibility scheme.

Practitioners are split on the need for presumptive eligibility

Our survey asked, "If the Department of Human Services is processing 95 percent of Medicaid and QUEST applications within five business days, do you believe that presumptive eligibility is necessary in the State of Hawai`i?" Nearly half of responding practitioners, 45 percent, indicated that they were not sure. Exhibit 2.13 displays the distribution of responses to this question.

Although practitioners are split on the necessity of presumptive eligibility, only a relatively small percentage (15 percent) of responding physicians believes that presumptive eligibility is unnecessary. To our survey respondents, presumptive eligibility remains a viable alternative to the current expedited application process.

Exhibit 2.13
Survey Response to the Question, "If the Department of Human Services is processing 95 percent of Medicaid and QUEST applications within five business days, do you believe that presumptive eligibility is necessary in the State of Hawai`i?"

	No.	Percentage
Yes	99	39.4%
No	38	15.1%
Not Sure	114	45.4%
TOTAL	251	99.9%

* Figures do not total 100 percent due to rounding.

Source: Office of the Auditor survey (2004)

Practitioners are unlikely to participate as qualified providers under a presumptive eligibility scheme

We queried practitioners about their willingness to participate as a qualified provider if presumptive eligibility were implemented, noting that a qualified provider would have responsibilities to determine eligibility and process applications with the State. Overall, 36 percent of responding physicians reported that they would not participate, another 36 percent was unsure, and only 29 percent indicated that they would participate as qualified providers.

To gauge the impact of practitioner participation as qualified providers, we adjusted the data to isolate responses from OB-GYNs and family and general practitioners. We found that even though respondents supported presumptive eligibility over the current expedited application process, they would not necessarily participate as qualified providers under presumptive eligibility. Exhibit 2.14 displays this relationship.

Of the 30 OB-GYNs that indicated presumptive eligibility was necessary even with an effective expedited application processing by the department, only nine, or 30 percent, indicated they would participate as qualified providers. The participation rate for family or general practitioners was 44 percent. Of those indicating the need for presumptive eligibility, 33 percent of OB-GYNs and 39 percent of family or general practitioners affirmed that they would not participate as qualified providers. Overall, 70 percent of OB-GYNs and 56 percent of

Exhibit 2.14
Willingness of Obstetrician-Gynecologists and Family or General Practitioners (FP) that Advocated for Presumptive Eligibility To Participate as Qualified Providers

	OB-GYN – Yes to presumptive eligibility		FP – Yes to presumptive eligibility	
Yes	9	30.0%	10	43.5%
No	10	33.3%	9	39.1%
Not Sure	11	36.7%	4	17.4%
TOTAL	30	100.0%	23	100.0%

Source: Office of the Auditor survey (2004)

family or general practitioners that indicated a need for presumptive eligibility also indicated that they would not, or were unsure if they would, participate as qualified providers.

Survey respondents also provided comments on presumptive eligibility. One proponent "...used to do it in the past." Comments from opponents included, "No time for paper work"; "no facilities or staff for this"; "Not unless clerical time was compensated at the same level as my (doctor) medical time seeing patients";and "No, no, no, no and no way! Staff already over-burdened."

The survey responses are also consistent with the response to an offer by an advocacy organization to train OB-GYNs in helping clients fill out the current expedited application forms. The training sessions were not held due to a minimal response to the offer. The advocacy group representative observed that many doctors do not have the staff or time to deal with extra paperwork.

There appears to be a "disconnect" between support of presumptive eligibility and a provider's willingness to participate as a qualified provider. Our data reveal that even if presumptive eligibility were established, some providers may not, or would not, participate. This potentially high non-participation rate could become a barrier to early prenatal care under a presumptive eligibility scheme if medical providers do not want to deal with the added responsibilities and turn away uninsured pregnant women.

Lack of insurance is perceived as the most significant barrier to care in Hawai`i

Respondents were given a set of identified barriers to prenatal care and were asked to select the top three. Exhibit 2.15 reveals that physicians felt that the top three barriers to early access to prenatal care are no insurance, no transportation to get care, and unawareness of pregnancy.

Exhibit 2.15
Top Three Barriers to Early Access to Prenatal Care in Hawai`i

	No.	Percentage
No insurance	211	32.0%
No transportation	160	24.2%
Not aware of pregnancy	97	14.7%
No child care for current children	77	11.7%
Difficulty in securing an appointment for prenatal care	60	9.1%
Other	55	8.3%
TOTAL	660	100.0%

Source: Office of the Auditor survey (2004)

Physicians identified other barriers to early prenatal care: poor knowledge about, or importance of, prenatal care; drug abuse or addiction; reluctance of young girls to reveal pregnancy to their parents; language barriers; shortage of OB-GYNs on the neighbor islands; and the pregnant woman's state of denial.

Our survey is consistent with other local and national studies—that a pregnant woman's insurance status is one of the most significant barriers to early prenatal care. Accordingly, increasing medical insurance coverage will improve pregnant women's access to early prenatal care.

Obstetrician-gynecologists average six days before seeing a new client

Obstetrician-gynecologists were asked to report the number of days between a new patient's request for an appointment and the actual visit. We found that the 65 OB-GYNs who responded averaged six days between the call for an appointment and the actual appointment. The days between the call and appointment ranged from a quick zero days, indicating immediate care, to a high of 21 days. Over half the respondents indicated that a pregnant woman might have to wait five days or longer for an appointment.

The department's five-day eligibility determination does not appear to be a barrier in terms of preventing a woman from seeking early prenatal care. Even with presumptive eligibility, pregnant women may have to wait over five days on average before securing an initial appointment for prenatal care.

The State would likely incur higher costs under presumptive eligibility

Under the current expedited application process, eligibility must be determined within five business days. If determined eligible, a pregnant woman is allotted 10 days to select a health insurance plan for coverage. Currently, the department offers three health plans: Hawai`i Medical Services Association (HMSA), Kaiser Permanente Hawai`i, and Aloha Care. The department pays a monthly capitated rate to the health plans, which, in turn, provide a negotiated series of medical services. The department does not pay for any services outside the plan's schedule. If a pregnant woman fails to select a plan by the tenth day, the department will select a plan for her. A medical care provider is reimbursed under the Medicaid fee-for-service reimbursement schedule for prenatal care given during the ten-day selection period.

Under presumptive eligibility, the department could have up to 60 days to determine permanent eligibility. During the 60-day period, pregnant women who have been presumed eligible by a qualified health care provider are allowed to seek medical care. All medical care services provided during the presumptive eligibility period are likely to be reimbursed by the State under the fee-for-service schedule.

To illustrate the potential health care cost differences between the current expedited process and a presumptive eligibility scheme, the department provided three actual cases of pregnant women who received medical benefits between January 1, 2004, and June 30, 2004. The cases selected for analysis reflect entry into the assistance program at varying points in a woman's pregnancy. For those three cases, the State paid a total of $933 in managed care premiums. However, under a presumptive eligibility scheme, the State would have paid $5,251, or 463 percent more, in fees for medical services provided to the three women in our analysis sample.

This cost comparison assumes that a fee-for-service reimbursement schedule was used during the presumptive eligibility period, that the applicant filed for permanent status the day after the presumptive eligibility determination was made, that the Med-QUEST Division took 45 days to determine permanent eligibility, and that the applicant took the ten-day maximum to enroll into a managed care plan. A cost comparison analysis is provided in Exhibit 2.16 based on those assumptions. These cost estimates do not include possible additional staffing and contract costs under a presumptive eligibility scheme.

Exhibit 2.16
Cost Comparison: Managed Care Under Expedited Application Processing v. Presumptive Eligibility

Trimester	Month of pregnancy in which client applied	# Of Services Received	Actual Managed Care Cost to State	Conversion of Managed Care costs to fee-for-service costs	+/- Difference between Managed Care and fee-for-service	Percent increase from actual managed care cost to fee-for-service
1	3rd Month	32	$445.16	$2,077.90	$1,632.74	366.8%
2	5th Month	23	$121.05	$593.82	$472.77	390.6%
3	9th Month	22	$366.41	$2,579.74	$2,213.33	604.1%
Totals		77	$932.62	$5,251.46	$4,318.84	463.1%

Note: The three cases selected received medical services between January 1, 2004, and June 30, 2004.

Source: Department of Human Services, Med-QUEST Division

While a qualified pregnant woman is almost assured of early access to prenatal care under a presumptive eligibility scheme, that intended benefit could come at a high cost to the State. If the department can achieve its goals under expedited processing, we believe that pregnant women can gain early access to prenatal care, get quicker enrollment into a managed care plan, and, as a result, receive medical services at a potentially lower cost to the State. In summary, the cost to the State could be higher under presumptive eligibility than under the present expedited process.

The faster the State can enroll an applicant into its health plans, the faster it can realize cost savings through the single capitated rate payment (as opposed to the fee-for-service payment schedule). Reimbursement costs to the State are probably more costly under the fee-for-service payment schedule. Furthermore, managed care health plans provide a "gatekeeper" function by monitoring treatment utilization. Under fee-for-service arrangements, the department is obligated to reimburse all medical procedures provided.

Conclusion

We found that the department failed to consistently meet its own standard of processing 95 percent of applications from pregnant women within five business days. However, it may be too early to draw any definitive conclusions about the application process, since the

department has had less than a year's experience with its initiative. Our audit itself was presented with only six months of data.

Notwithstanding the limited data, we found that the department's shortfall was exacerbated by inconsistent definitions of the five-day period, different processing standards for the Benefits, Employment, and Support Services Division and federally qualified health centers, inconsistent data that omitted one processing source, and superfluous data that should not be included, thereby skewing compliance results in favor of the department. The flawed data measurements are particularly problematic as they leave department administrators without an effective tool to evaluate their process. Furthermore, the lack of a non-compliance penalty leaves staff little incentive, on a long-term basis, for meeting the five-day standard.

Additionally, we found that other eligibility groups may be adversely impacted by the expedited application process for pregnant women. However, the department has not assessed the impact of the new expedited processing on other eligibility groups nor does the department have any way to determine the need for adjustments. Despite these shortcomings, the department has made improvements in processing applications from pregnant women.

We also found that presumptive eligibility may not be better than the present expedited process. Although 32 U.S. states and territories offer presumptive eligibility, reduced federal requirements and department efforts to streamline the application process render presumptive eligibility unnecessary. A survey of local medical providers found mixed views on both expedited processing and presumptive eligibility. The survey also revealed that the five-day waiting period should not pose a medical hardship to pregnant women; some medical practitioners currently limit or refuse to accept Medicaid patients; and many practitioners might not, or would not, participate as qualified providers if presumptive eligibility were enacted. We found that presumptive eligibility might become a barrier to early prenatal care. Finally, we found that the State may incur higher costs under a presumptive eligibility scheme.

Before turning to a presumptive eligibility scheme, the department needs to have further experience with expedited processing, time to implement improvements and adjustments, and feedback from its stakeholders.

Recommendations

1. The director of the Department of Human Services should:

   a. Evaluate data gathering methods and develop a consistent and accurate reporting system by:

      i. Including applications processed by the Benefits, Employment, and Support Services Division in its statistical reports;

      ii. Excluding from the department's data gathering "duplicate" applications that do not require processing;

      iii. Reporting monthly statistics for each unit of the Med-QUEST Division and using those figures to assess compliance with the standard of processing 95 percent of applications from pregnant women within five business days.

   b. Disseminate written instructions to Med-QUEST Division and Benefits, Employment and Support Services Division staff, and to all federally qualified health centers on how application processing time is to be calculated;

   c. Ensure that all Med-QUEST Division staff uniformly apply the five-day processing standard among Med-QUEST Division units;

   d. Propose an amendment to Section 17-1711-13, Hawai`i Administrative Rules, to change the eligibility determination deadline for pregnant women to five days, with a presumption of eligibility on the sixth day;

   e. Submit a report to the 2006 Legislature to include, but not be limited to:

      i. Statistics on processing applications from pregnant women for calendar year 2004 and compliance with the application processing standard;

      ii. Method for calculation of department statistics;

      iii. Confirmation that the department conformed the application process for all intake sources, including its department units and federally qualified health centers;

iv. Efforts to improve coordination between the Benefits, Employment and Support Services Division and the Med-QUEST Division to ensure timely processing of applications from pregnant women; and

v. Feedback from advocacy groups and stakeholders regarding the expedited application process.

2. If the Legislature determines that presumptive eligibility is necessary, it should:

   a. Ensure that the department and pregnant women advocacy groups work jointly to gain the participation of medical providers by:

      i. Establishing the simplest presumptive eligibility program allowable by law; and

      ii. Educating medical providers about the presumptive eligibility program; and

   b. Ensure that adequate resources are available to support the program.

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Appendix A

This table shows the weighted distribution of the socioeconomic characteristics of the study population. the uninsured rate for pregnant women was 11.6 pecent, slightly higher than the statewide rate of 10 percent. The report also found that uninsured women were more likely to receive no prenatal care or to enter prenatal care late (44.5 percent) than insured wome (17.3 percent).

Demographic Characteristics of Resident Women Giving Birth in Hawai`i, PRAMS 2000-2001

Characteristics	Total Percent (weighted n=33,991)	Not Insured before pregnancy (weighted n=3,909)	Insured before pregnancy (weighted n=29,983)
Age* **			
<20	10.3	17.6	9.3
20-24	24.9	35.7	23.4
25-34	48.0	37.7	49.4
>34	16.8	9.0	17.8
Education* **			
<12 years	9.5	14.9	8.8
12 years	41.4	51.2	40.1
>12 years	49.0	33.9	51.1
Marital Status* **			
Married	67.7	46.0	70.7
Not Married	32.3	54.1	29.3
Residential Area* **			
Urban Honolulu	50.2	41.9	51.2
Rural Oahu	23.7	23.7	23.7
Neighbor Islands	26.1	34.4	25.0
Race/Ethnicity* **			
Filipino	20.7	19.9	20.8
Hawaiian/Part Hawaiian	27.0	33.4	26.3
Other Asian and Pacific Islander	25.6	26.1	25.5
Other Nonwhite	4.1	2.5	4.3
White	22.5	18.2	23.2
1st Trimester Prenatal Care* **			
Yes	79.6	55.9	82.7
No	19.0	40.6	16.2
No Prenatal Care	1.4	3.5	1.1
Poverty Level			
<100%	33.0	61.3	29.5
101-185%	24.1	23.9	24.1
186% +	42.9	14.8	46.4
Income* **			
<$10,000	14.5	30.7	12.5
$10,001-30,000	31.9	46.6	30.0
$30,001-50,000	25	15.5	26.1
$50,001 +	28.7	7.2	31.4

Pecentages may not add to 100 because of rounding.
Note***p<0.001

Source: Nighat Quadri, et al., *Insurance Status as a Barrier to Early Entry Into Prenatal Care in Hawaii,* Department of Health, December 2003, p. 9.

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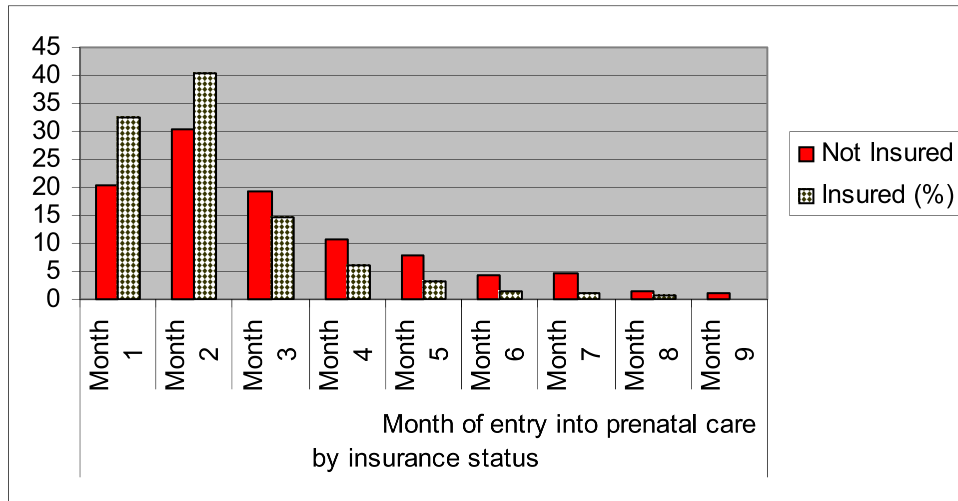
Appendix B

This table displays the month of entry into prenatal care by prior insurance status. The percentages of women with insurance who entered prenatal care in the first three months of pregnancy were 32 percent, 41 percent, and 15 percent, respectively, compared to 20 percent, 31 percent, and 19 percent for women without insurance. Estimation of relative risk indicated that women without insurance in Hawaii were at two and half times the risk of not entering prenatal care in the first trimester.



Source: Nighat Quadri, et. al., *Insurance Status as a Barrier to Early Entry Into Prenatal Care in Hawaii*, Department of Health, December, 2003, p. 10.

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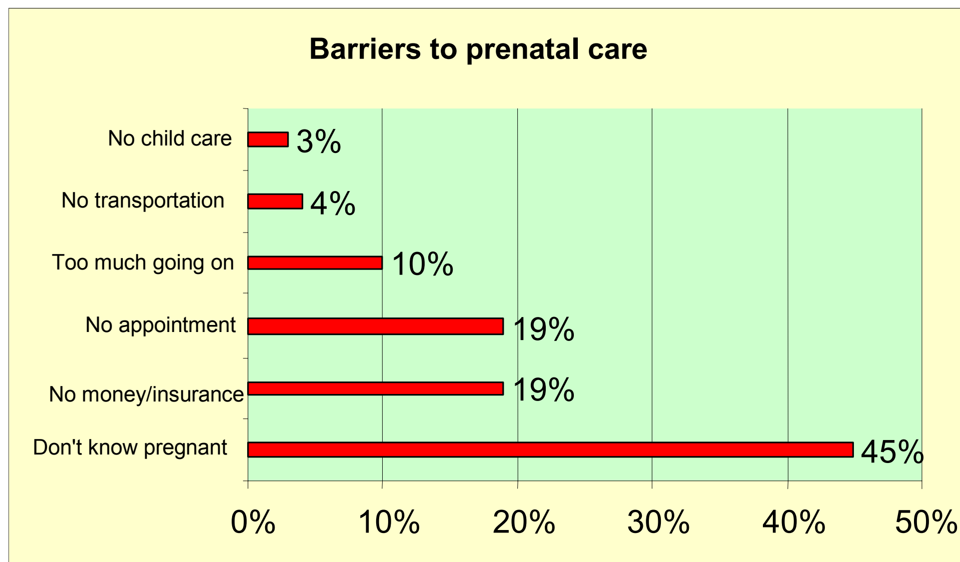
Appendix C

The graph shows the barriers to first-trimester prenatal care. An estimated 19 percent of all PRAMS respondents stated that they did not get prenatal care as early as they wanted. The three barriers reported most often were: "*not knowing if pregnant or wanted an abortion*" (45%), "*lack of money or insurance to pay for care*" (19%), and " (19%). Needing transportation, being too busy, not having childcare available, and other barriers were reported less frequently.



Source: Nighat Quadri, et. al., *Insurance Status as a Barrier to Early Entry Into Prenatal Care in Hawaii*, Department of Health, December, 2003, p. 11.

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Appendix D

The report notes:

> The frequency with which barriers to early prenatal care were reported varied by income level. Not knowing about the pregnancy was the most commonly mentioned barrier by women of all income levels; however, among women with incomes below the poverty level, the next most common barriers were not having enough money or insurance (24.6%) and not being able to get an appointment (15.7%). For women with incomes of 186 percent of poverty or more, the next most common barriers were not being able to get an appointment (25.1%) and the doctor or plan would not start care (10.6%). This table reveals the barriers to early prenatal care, adjusted to reflect a woman's income level as a percentage of the federal poverty level.

Barriers to Early Prenatal Care by Income Level

	Total	0-100% FPL	101-185% FPL	186%+ FPL
Didn’t know pregnant	46.4%	46.8%	40.3%	51.8%
No appointment available*	19.2%	15.7%	20.5%	25.1%
No money/insurance**	18.4%	24.6%	15.6%	8.7%
No Medicaid card**	5.7%	9.2%	4.0%	0.2%
Too much going on*	7.9%	9.3%	9.7%	3.2%
No transportation**	3.9%	7.1%	0.9%	0.2%
Doctor or plan wouldn’t start**	7.3%	2.6%	13.5%	10.6%

*p<.05 FPL = federal poverty level
**p<.001

Source: Nighat Quadri, et. al., *Insurance Status as a Barrier to Early Entry Into Prenatal Care in Hawaii*, Department of Heatlh, December, 2003, p. 11.

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Notes

Chapter 2

1. Nighat Quadri, Dr. Cheryl Prince, Limin Song, and Loretta Fuddy, *Insurance Status as a Barrier to Early Entry into Prenatal Care in Hawai`i*, Department of Health, December 10, 2003.

2. Cunningham, F. Gary, et. al., *Williams Obstetrics, 21st Edition*, McGraw Hill, June 2002, p. 224 (citing Fiscella, 1995)

3. Cunningham, F. Gary, et. al.,*Williams Obstetrics, 21st Edition*, McGraw Hill, June 2002, p. 224 (citing Kogan and Colleagues, 1998)

4. Cunningham, F. Gary, et. al., *Williams Obstetrics, 21st Edition*, McGraw Hill, June 2002, p. 225 (citing Olds and associates, 1986, 1997, 1998).

5. Scott, James R., et. al., *Danforth's Obstetrics and Gynecology*, Lippincott Williams & Wilkins, August 2003, pp. 1-2.

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Human Services. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department agrees with the report's findings that improvements have been made in processing applications from pregnant women and that presumptive eligibility may not provide a better alternative to expedited application processing. The department also concurs with all recommendations presented in the draft report and highlighted actions the department has undertaken, or will undertake in the near future, to address many of the concerns identified in our draft report.

While the department is in general agreement with our report findings, it makes several clarifying points. First, its view is that our office appears to define the completion of the five-day process to be the date the eligibility determination was communicated to the applicant as documented in the department's computer database system. This view is not correct. As the draft clearly states, we calculated the end of the five-day period as the date an eligibility determination is made. This disposition date is captured in the computer system, and that is the date we used in our calculations. We did not use the date the eligibility determination was communicated to the applicant and, therefore, stand by our calculations.

Secondly, the department comments that an application that could not be located during our fieldwork on Maui was, in fact, found and presented to audit staff for review. Our testing files indicate that the file was not found. We note that the single missing file did not adversely impact our finding on the Maui office's performance.

Thirdly, the department believes that cases eliminated from the original sample size should have been replaced through the selection of additional cases to maintain statistical significance. We amended the report to address the department's concerns, but note that the amendments do not significantly change the testing outcomes. We further note that the department's response acknowledges we preserved the statistical validity of our test sample, but we amended the report text anyway to clarify our findings.

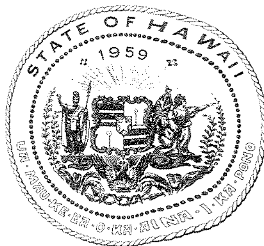
Fourth, the department challenges our finding that federally qualified health centers (FQHC) are subject to varying standards because the

department has reliable information to the contrary. We disagree. Our review found that some FQHC staff have different interpretations of the five-day standard. Furthermore, Med-QUEST Division staff, too, have varying interpretations of the five-day standard and would apply these varying interpretations in processing application from FQHCs. Furthermore, the response cites that FQHCs statewide reported a 97 to 99 percent compliance rate with the five-day process. We submit that, as our report findings indicate, reliance on aggregate, statewide figures do not paint an accurate picture of what may be happening at individual facilities or facilities located in a particular geographic area.

Fifth, the department states that current policies and procedures require the Benefits, Employment, and Support Services Division (BESSD) to determine Medicaid eligibility for the aged, blind, and disabled (ABD) population. The department asserts that, accordingly, all applications for blind and disabled pregnant women would be processed by BESSD. We do not dispute BESSD's role in determining eligibility for the ABD population. According to Med-QUEST Division policies and procedures and verbal confirmation by Med-QUEST Division staff, however, we were led to believe that *all* pregnant women applications are to be sent to the Med-QUEST Division for expedited processing. As identified in our report, applications from pregnant women processed by BESSD are not included in the department's statistics. We note that the director clarifies BESSD's role in determining eligibility for pregnant women through a draft directive attached to the department's response.

Finally, the department provided additional information and points of clarification, some of which were included in the final report.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

November 16, 2004

COPY

The Honorable Lillian B. Koller
Director
Department of Human Services
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Ms. Koller:

Enclosed for your information are three copies, numbered 6 to 8 of our confidential draft report, *Audit of the Department of Human Services' Expedited Application Process for Pregnant Women.* We ask that you telephone us by Thursday, November 18, 2004, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, November 26, 2004.

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

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting 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,

Marion M. Higa
State Auditor

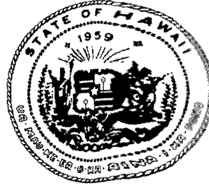
Enclosures

ATTACHMENT 2

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy and Program Development Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 26, 2004

RECEIVED
Nov 26 1 56 PM '04
OFC. OF THE AUDITOR
STATE OF HAWAII

Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

SUBJECT: RESPONSE TO AUDIT OF THE DEPARTMENT OF HUMAN SERVICES' EXPEDITED APPLICATION PROCESS FOR PREGNANT WOMEN

Thank you for the opportunity to respond to the Office of the Auditor's draft report on the "Audit of the Department of Human Services' Expedited Application Process for Pregnant Women" received on November 16, 2004. The Department fully agrees with the assertion that improvements have provided access to early prenatal care and that it is too early to draw any definitive conclusions about the efficacy of the expedited application process and the recommendation that a full twelve (12) months of data would provide a better picture of the Department's ability to meet its standards.

The Department strongly believes that timely and regular prenatal care enhances the birth of a healthy baby, lessens the probability of a complicated delivery or a low weight baby with health problems and prevents additional costly medically necessary services. Prenatal care for pregnant women provides the healthiest start for newborns and reduces medical costs.

Many factors influence timely prenatal care for pregnant women. The Department agrees that in spite of the lack of health insurance, the limited availability of medical providers to service pregnant Medicaid clients in the community is a major barrier to both the current expedited application process and a presumptive eligibility scheme. In concert with the views of physicians, other barriers including lack of knowledge or importance of prenatal care, drug abuse or addiction, reluctance of minor girls to reveal their pregnancy to their parents, language barriers, shortage of Obstetricians -Gynecologists (OB-GYN) on the Neighbor Islands, lack of transportation, and the general denial of pregnancy.

The Med-QUEST Division has increased enrollment of pregnant women in the first six months of 2004 than in the same time period in 2003 by 8.3% (pg. 23). While federal regulations

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proffered by the Centers on Medicare and Medicaid Services (CMS) mandate that only the State is authorized to conduct Medicaid eligibility determinations, Hawaii has improved accessibility to public health insurance by reimbursing all Federal Qualified Health Centers (FQHCs) for outstationed eligibility workers who provide assistance to pregnant women within their communities instead of through traditional State offices.

Department of Human Services Concurrence with the Office of the Auditor:

Current Expedited Application Processing

The Department's "Expedited Processing of Pregnant Women Applications" not only addresses the concern of health insurance as a barrier to prenatal care but also offers women better assurance of health care coverage throughout the entire pregnancy period. Positive perceptions of pregnant women advocacy groups, health care provider groups, community health centers and government monitoring agencies (CMS) (pgs. 24-25) related that Med-QUEST's simplified applications and faster processing time is indicative of the Department's improvements and efforts. The report reveals that 72 percent of OB-GYNs and 77 percent of family or general practitioners felt the five-day period was acceptable and did not generally pose a medical hardship to pregnant women. Exemplified in current practice, pregnant women wait an average of over five days before securing an initial appointment for prenatal care. The Department appreciates the Auditor's belief that the Department has made good progress in its effort to reduce barriers to health care and should continue future improvements to meet its standards.

The Department appreciates the Auditor's findings that the Maui Med-QUEST Unit achieved a 100% rating for the processing of pregnant women applications within the five-business-days process.

Related to cost effectiveness and efficiency, the Auditor's opinion that pregnant women who are quickly enrolled in a managed care plan allows for early access to prenatal care at a potentially lower cost to the State. Furthermore, the added value of managed care plans monitoring and reporting treatment utilization as a condition of their contracts with the State ensures the provision of quality care.

Presumptive Eligibility

Presumptive eligibility may ensure initial health insurance coverage but does not guarantee continuous coverage (pg. 29). Instead, to combat the cumbersome Medicaid eligibility process, Hawaii has streamlined its application process through a simplified Children and Pregnant Women Application, faxed applications and most recently initiated self-declaration of pregnancy status. These simplification efforts were not only well received by the community, but also reduced staff application processing functions.

Despite the openness of the Federal government to simplify the application process, federal requirements regulating presumptive eligibility continue. It requires a two step process beginning with a qualified health care provider making the initial eligibility determination and the

submission of an application to the State Eligibility Office no later than the last day of the month following the month in which the determination was made for official determination. If the application is not filed in time or the pregnant woman is found to be ineligible, health care coverage ends. It is important to note that presumptive eligibility may not allow coverage for labor and delivery services as it does not ensure coverage throughout the term of a woman's pregnancy.

The survey of 655 OB-GYNs revealed a range of opinions with only 9% responding that the expedited application process was inadequate and resulted in the Auditor's opinion that it is an indication of encouragement for the Department. More importantly, while health care providers were split on the necessity of presumptive eligibility, 36 percent of the physicians reported that they would not participate, another 66 percent were unsure and only 29 percent indicated that they would participate as qualified health care providers (Chart pg. 36). The survey also found that 70 percent of OB-GYNs and 56 percent of family or general practitioners indicated a need for presumptive eligibility but would not commit to becoming qualified health care providers. The Auditor's opinion that even with the advent of presumptive eligibility, the potentially high non-participation rate would itself become a barrier to early prenatal care is significant. Since Federal provisions only allow FQHCs and certain hospitals to be "qualified providers" to determine presumptive eligibility, a significant number of pregnant women who are under the care of independent physicians in the community would not benefit from implementation of presumptive eligibility.

The prohibitive cost of presumptive eligibility as illustrated in Exhibit 2.16 (pg. 40) of 463.1 percent illustrates higher costs further taxing the State's budget under the fee-for-service reimbursement system. The projected increase reflects only the cost for services and does not factor additional staffing, monitoring and contract costs further exacerbating the total cost of the initiative. The Department believes that the increased costs could itself become a barrier to early prenatal care by necessitating a reduction of benefit coverage, further distancing the Department from its goal to assure early, comprehensive and quality health care. Finally, the Department appreciates the Auditor's conclusion that presumptive eligibility may not be better than the present Expedited Processing of Pregnant Women Applications.

Department of Human Services Clarifications

Five Day Application Processing

Implementation of this new initiative required several procedural iterations which may have resulted in the inconsistent interpretation and application of the expedited processing standards. The Department maintains the five-business-day clock to process pregnant women applications commences the day a completed application is received and ends the day an official eligibility determination is made. In contrast, the Office of Auditor appears to define the completion of the five-day process to be the day the eligibility determination was communicated to the applicant as documented in the Department's Hawaii Automated Welfare Information (HAWI) system. The

difference in the calculation standard resulted in the Office of the Auditor's determination of an average number of 6.8 days (Pg. 16) for the Oahu Med-QUEST Units. This differing perspective infers that if the eligibility determination letter was sent the following business day, the Department would be out of compliance and in effect allows the Department only four (4) days to complete the eligibility determination. Of interest, even within the Office of the Auditor's restricted time frame, the Maui Med-QUEST Unit still attained a rating of 100%.

The report also noted on Maui that an application could not be located in the case file. The Department submits that it was located and presented to the Auditor prior to his departure from the review.

The Auditor references that expedited processing of pregnant women may also adversely impact processing times for other eligibility groups. Current rules mandate 45 day and 60 day time periods for eligibility determinations for specific populations. Priority processing inherently demands immediate action assuming impact on other functions. Although Department data were produced documenting application and approval dates for the entire Medicaid population within a designated time period, the Office of the Auditor declined to analyze the data due to time constraints. Therefore, the Department proffers that processing times for other eligibility groups may not have been adversely impacted and were completed within the mandated time frames.

The Office of the Auditor's original sample size of 76 individuals for Oahu was pared to 65 individuals due to their exclusion of 11 applications deemed to be invalid because the applicant was already receiving medical assistance, also referred to as "duplicate applications." The Department contends that cases with a non-pregnant individual not receiving benefits due to income or asset ineligibility who then becomes pregnant may be eligible due to increased income eligibility standards (185%) and no asset requirement should be considered as a "new application" and therefore included in the sample size. Since HAWI does not differentiate between a pregnant woman applying for health insurance for herself from one who may be applying for others, cases falling under these guidelines should have been retained in the sample size. Additionally, the Department believes that cases eliminated from the original sample size should have been replaced through the selection of additional cases to maintain statistical significance. Finally, the Department strongly asserts that recognition of the pre-screening functions required to identify pregnancy status to qualify for expedited processing is an integral part of the expedited process. Despite the position of the Auditor, the Department is appreciative that the report does concede an increase to 71 percent with the restoration of the "duplicate" cases.

The report states that applications submitted by FQHCs are subject to varying standards; however we have reliable information to the contrary. Outstationed eligibility workers at FQHCs statewide have reported to the Hawaii Primary Care Association that 97 to 99 percent of their <u>completed</u> pregnant women applications are processed within five business days. However, the time varies between the Neighbor Islands and Oahu with the former averaging two days and the latter averaging four days. Subsequent to implementation of the Expedited Processing of Pregnant Women Applications, the Oahu outstationed eligibility workers discussed the definition of five-business-days at meetings with

Med-QUEST staff in April 2004 and September 2004. It was emphasized the clock commences the day a completed application is received and ends the day an official eligibility determination is made. Furthermore, Hawaii Covering Kids has partnered with Med-QUEST since November 2003 to conduct eighteen community training workshops on Hawaii, Maui, Molokai, and Oahu for 143 participants from 49 organizations where this definition for Expedited Processing of Pregnant Women Applications was highlighted. It is also explained by outstationed eligibility workers and trainers that a pregnant woman who needs urgent help can go to a Med-QUEST office where she will be seen right away and can be given an immediate eligibility determination.

Cited in the report was that BESSD units kept pregnant women applications for processing by their own staff rather than transmitting them to Med-QUEST for expedited processing. The Department submits that current policies and procedures require BESSD to determine medicaid eligibility for the Aged, Blind and Disabled (ABD) populations. Therefore, any applications for blind and disabled pregnant women would be processed by BESSD (pg.20).

Staff shortages reflect a stable Neighbor Island contingent and on-going recruitment and retention difficulties on Oahu. Specifically, the unstable clerical work force significantly affected the identification, registration and support services for expedited eligibility processing. Finally, the abolishment of fifteen MED-QUEST positions by the Hawaii State Legislature effective July 1, 2004 has significantly taxed Med-QUEST's operations, increased workloads and affected timely outcomes.

Recommendations:

1. The Director of the Department of Human Services should:

a. Evaluate data gathering methods and develop a consistent and accurate reporting system by:

i. Including Applications processed by the Benefits, Employment, and Support Services Division in its statistical reports;

The Department concurs with the recommendation. Effective November 2004, BESSD will fax all pregnant women applications (DHS 1240, 1100, 1108) to Med-QUEST Eligibility Branch (EB) (see attached Draft PC04-, ICF dated 11/24/04) no later than one day from receipt for determination of Medicaid eligibility. This action will ensure the inclusion of all BESSD pregnant women applications in the Division's monthly manual report.

In addition, the Department will enlist the services of the Hawaii Primary Care Association's Outreach and Assistance Project to require outstationed eligibility workers at FQHCs to complete separate application forms for Financial (DHS 1240) and Medical Assistance (DHS 1108/1100) and fax DHS 1108/1100 Medical Assistance Application

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directly to the Med-QUEST Eligibility Branch and DHS 1240 separately to BESSD. This action will eliminate the time delay that occurs when BESSD receives and forwards the application to Med-QUEST.

ii. **Excluding from the Department's data gathering "duplicate" applications that do not require processing;**

The Department concurs with the recommendation but will initiate a separate internal report to track and document all cases subjected to the pre-screening work associated with pregnant women applications by BESSD.

The Department will also initiate a Systems request to differentiate pregnant women applying for health insurance for themselves from those applying for others. The addition of a pregnant woman not receiving health insurance benefits to an existing case will be defined as an application, afforded expedited processing and included in the Med-QUEST monthly manual report.

iii. **Reporting monthly statistics for each Unit of the Med-QUEST Division and using those figures to assess compliance with the standard of processing 95 percent of applications from pregnant women within five business days.**

The Department concurs with the recommendation and is in current compliance. All MQD Units that process applications are required to submit monthly reports on the number of pregnant women applications received, processing times and explanations for non-compliance.

The Department will also initiate a Systems change request to generate a monthly ad hoc management report of all pregnant women applications documented in HAWI by Division, Section and Unit. The report will then be compared and reconciled (if necessary) with the manual report.

The Department will also implement quarterly internal audits conducted by the Management Services Office to objectively review the accuracy and quality of the manual reports until 100% accuracy is attained. Thereafter, the audits will occur semi-annually.

b. **Disseminate written instructions to Med-QUEST Division and Benefits, Employment and Support Services Division staff, and to all federally qualified health centers on how application processing time is to be calculated;**

The Department concurs with this recommendation and has developed the written instructions (see attached ICF dated 11/24/04, Draft PC 04-). A letter will be mailed by November 30, 2004 to all FQHCs and the Department's other community partners with the same information on calculating the five-business-day processing time for complete applications.

c. **Ensure that all Med-QUEST Division staff uniformly applies the five-day processing standard among Med-QUEST Division units;**

The Department concurs with this recommendation. All Med-QUEST Division Units were mandated to uniformly comply with the five-business-days processing standard through a written Internal Communication Form (see attached ICF dated 11/24/04, Draft PC 04-).

The Med-QUEST Eligibility Branch Administrator is mandated to monitor Unit Supervisors for compliance and develop corrective action plans when job performance is incomplete or inferior, which can lead to disciplinary action. In turn, Unit Supervisors are mandated to monitor Eligibility Workers for compliance and develop corrective actions when job performance is incomplete or inferior, which could lead to disciplinary action.

d. **Propose an amendment to Section 17-1711-13, Hawaii Administrative Rules, to change the eligibility determination deadline for pregnant women to five days, with presumptive eligibility on the sixth day;**

The Department agrees to initiate an amendment to Section 17-1711-13, Hawaii Administrative Rules, to change the eligibility determination deadline for completed pregnant women applications to five days.

However, the Department must research federal regulations and consult with CMS for approval to implement presumptive eligibility on the sixth day for a specific segment of the Medicaid population (pregnant women). Failure to comply with Federal regulations may result in the loss of federal matching funds and potential legal challenges.

e. **Submit a report to the 2006 Legislature to include, but not be limited to:**

i. **Statistics on processing applications from pregnant women for calendar year 2004 and compliance with the application processing standard;**

ii. **Method of calculation of department statistics;**

The Department concurs with the recommendations and the above information in the report.

iii. **Confirmation that the department conformed the application process for all intake sources, including its department units and federally qualified health centers;**

iv. **Efforts to improve coordination between the Benefits, Employment and Support Services Division and the Med-QUEST Division to ensure timely processing of applications from pregnant women; and**

v. **Feedback from advocacy groups and stakeholders regarding the expedited application process.**

The Department concurs with these recommendations. On going coordinated efforts and implementation of new strategies (PCA initiative in 1.a. above) with BESSD will continue resulting in new and updated policy and procedure clarifications (see attached Draft PC 04, ICF dated 11/24/04) to ensure expedited processing of pregnant women applications.

Through the partnerships with the Hawaii Primary Care Association and Hawaii Covering Kids, the Department receives feedback from advocacy groups and stakeholders through regularly scheduled meetings, trainings and annual statewide conferences. In addition, the Department will continue to be open and responsive to any and all feedback from the community.

2. **If the Legislature determines that presumptive eligibility is necessary, it should:**

a. **Ensure that the department and pregnant women advocacy groups work jointly to gain the participation of medical providers by:**

i. **Establishing the simplest presumptive eligibility program allowable by law; and**

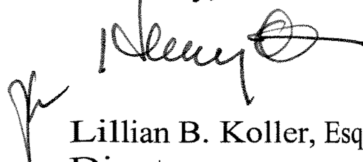
ii. **Educating medical providers about the presumptive eligibility program; and**

The Department does not support the initiation of presumptive eligibility for pregnant women. However, if mandated through statute by the Legislature the Department will comply.

a. **Ensure that adequate resources are available to support the program.**

The Department does not support the initiation of presumptive eligibility for pregnant women. However, if mandated through statute, additional budget appropriations will be requested and must be received in order to implement the initiative. Funding for additional staff positions, information system development, fee-for-service costs, training, contracting costs and operational expenses will be required.

Sincerely,



Lillian B. Koller, Esq.
Director

Attachments (2)

Draft

PROGRAM CLARIFICATION

PC NO.: 04-
SUBJECT: PROCESSING MEDICAL APPLICATIONS FOR PREGNANT WOMEN
SECTION(S):
ORIGINATOR(S): D. Matsuoka, F. Chi
EFFECTIVE DATE: Immediately
ISSUE DATE: 11/24/04

INFORMATION ONLY:
☐ FS ☐ FA ☒ CCCH ☒ CCL ☒ FTW ☒ E&T

ACTION REQUIRED:
☒ FS ☒ FA ☐ CCCH ☐ CCL ☐ FTW ☐ E&T

FOR INFORMATION:

This rescinds and reissues PC 04-076, Processing Medical Applications for Pregnant Women, with major changes. Based on a recent audit, the Department is not complying with the Director's mandate to process medical applications for pregnant women within five business days. New procedures have been developed to ensure timely processing of these cases. **These procedures must be followed even if BESSD expects to process the application within five business days.**

FOR ACTION:

1. **BESSD screening and referral process**: Staff shall identify all financial, financial/food stamp or food stamp only applications requesting medical assistance which include a pregnant woman (adults as well as dependent children). Previous procedures only required staff to screen the DHS 1100, Application for Medical Assistance; however, staff will now be required to screen the DHS 1240, DHS 1100 or the DHS 1108, Application for Children and Pregnant Women.

   BESSD staff must fax applications which include a pregnant woman to the respective MQD section/unit no later than the next business day following the date of application. BESSD staff shall identify these applications by writing "PW" in the upper right hand corner on the front of the application. Attach a fax cover sheet notating that the application is for a pregnant woman and identify the BESSD unit assigned to process the FA and/or FS application.

   At a minimum, an application for a pregnant woman is considered complete if it is signed. The priority is for the DHS 1100 to be faxed, however, if the DHS 1108 is submitted, this form can be faxed. If neither of these forms is completed, staff shall fax the DHS 1240. The original copy

of the application shall be retained in the BESSD case record together with the confirmation sheet that the application was faxed to MQD.

If pregnancy is not declared on application, but is discovered during the interview, the application shall be faxed following these procedures. The application shall be faxed no later than the next business day after the interview.

2. **Adding a medical program**: If active BESSD client requests medical assistance, client shall complete the DHS 1100. BESSD staff shall fax application to MQD and follow the previously outlined procedures.

3. **Exceptions to screening and referral process**:

   a. Pregnant woman requesting food stamps only: The DHS 1240 does NOT have to be faxed to MQD when a pregnant woman is requesting food stamps only and has NOT completed the DHS 1100 or DHS 1108. However, if the DHS 1100 or DHS 1108 is completed, the application shall be faxed to MQD.

   b. ABD application which includes a pregnant woman: BESSD shall make the medical disposition for applications which include a pregnant woman within five business days following the date of application. However, if during the screening process, the pregnant woman is not identified as an ABD, the application shall be faxed to MQD for processing.

   c. Termination of ABD benefits: When ABD benefits are terminated in a case which includes a pregnant woman, BESSD staff shall open a medical case within five business days of termination date.

Note: The medical standard for a pregnant ABD woman is 185% of FPL.

3. **HAWI procedures**: In order to assist MQD in tracking cases with pregnant women, these procedures shall be followed for both applicants and recipients in all financial cases to ensure accurate data:

   a. Identify the pregnant woman by entering a "Y" on the SSDO screen in the "PW" field. **Remove "Y" after child is born.**

   b. Add the unborn child to the financial case as "UB". Follow procedures in HAWI Handbook, Section 600, Case (Client) Maintenance.

4. **Procedures if FA is approved**: Notify MQD of BESSD approval; MQD shall take appropriate action to close the medical case for the pregnant woman.

Please call your respective program office if you have any questions regarding this PC.

/s/
ABESSDA

☐ Attachment(s)

Historical Reference: PC 04-076, Processing Medical Applications for Pregnant Women.

INTERNAL COMMUNICATION FORM DEPARTMENT OF HUMAN SERVICES	
Subject: PROCESSING OF PREGNANT WOMEN ONLY MEDICAL APPLICATIONS	**Originator:** L. Hiramoto/28138

To: EBA
Attn: EB Sections and Units

From: MQDAA

Date: 11/24/04

Memo No. 1

FOR INFORMATION

In the recently completed audit of the DHS expedited application process for pregnant women, the State Auditor found that, during the period reviewed the Department has not met its target of processing 95% of those applications within the 5-day timeframe. This initiates corrective action to bring the Department into compliance with its self-designated processing timeframe.

Definition of the 5 day timeframe

The 5-workday timeframe shall begin on the working day that a completed application form for a pregnant woman is received by the Department. A "work-day" is a DHS workday.

The workday on which the completed application form is received is "Day 1" of the 5-day timeframe. The 5-day timeframe ends on "Day 5", which is the 4th workday following "Day 1".

- An application form for a pregnant women is "completed" if:
  1. Pregnancy is declared;
  2. Information for determining basic and financial eligibility is provided; and
  3. The application form is signed by the applicant.
- If any application form is not "completed" as defined above, the applicant shall be allowed 10 calendar days to provide the information or signature required for the application form to be "completed". When the information or signature is received, the application form will be considered "completed", which begins the 5-day timeframe.

An application shall be considered processed upon entry of the eligibility determination in HAWI, the Department's automated eligibility system.

Coordination with BESSD for Applications for Financial Assistance or for Medical Assistance Only, when a Pregnant Women is Included.

The 5-day timeframe for processing applications for pregnant women begins on the working day the Department receives a completed application. Because an application for financial assistance is widely considered a simultaneous request for medical assistance, a completed application form for financial assistance or medical assistance only that is received by BESSD will start the 5-day timeframe for a pregnant woman.

To expedite the medical assistance eligibility processing, BESSD will screen all applications received, identify any pregnant women, identify the date of receipt of the form, and transmit via FAX the pertinent

Subject:	PROCESSING OF PREGNANT WOMEN ONLY MEDICAL APPLICATIONS	Originator:	L. Hiramoto/28138

To: EBA
Attn: EB Sections and Units

From: MQDAA

Date: 11/24/04

Memo No. 1

application form, whether a DHS 1100, DHS 1108, or DHS 1240 to the designated MQD office on the island. BESSD will transmit the appropriate application form to MQD no later than "Day 1" of the 5-day timeframe.

Upon receipt of the FAX transmission, MQD shall determine if the application form is completed and subsequently process the application within the 5-day timeframe.

Procedures for Timely Processing Application for Pregnant Women.
As described above, all applications for medical assistance for non-blind or disabled pregnant women will be processed by MQD. All applications for blind or disabled pregnant women that were received by BESSD shall be processed by BESSD within the 5-day timeframe. For that reason, the MQD Policy and Program Development Office (PPDO) has started to draft detailed procedures for processing of applications for pregnant women by MQD Eligibility Branch offices. PPDO will coordinate with BESSD as the procedures are developed. When issued and implemented by MQD Eligibility Branch, the result will be uniform processing of medical assistance applications for pregnant women statewide.

PPDO will issue the procedures described above no later than 11/30/04.

If there are any questions, please forward them through channels to PPDO.

MQDAA

c: MQD Branches (CSB, HCMB, MSB), MQD Staff Offices (FO, SO, TO), BESSD, SSDA, AAO, MSO (QC), OIT