Review of the Progress Report on Maximizing Federal Medicaid Funds for Hawaii

A Report to the Governor and the Legislature of the State of Hawai'i

Conducted by

Lewin/ICF
and
Fox Health Policy Consultants

Report No. 91-3
January 1991

THE AUDITOR
STATE OF HAWAI'I

The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

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THE AUDITOR
STATE OF HAWAII

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OVERVIEW

THE AUDITOR
STATE OF HAWAII

Review of the Progress Report on Maximizing Federal Medicaid Funds for Hawaii

Summary

The Legislature asked the auditor to report to the 1991 Legislature on the progress made by the Department of Health and the Department of Human Services in implementing the recommendations of the *Study and Plan for Maximizing Federal Medicaid Funds for Hawaii*, prepared for the Office of the Auditor by Lewin/ICF and Fox Policy Consultants in 1990. We asked these consultants to review and assess the *Progress Report On Maximizing Federal Medicaid Funds For Hawaii* submitted by the two departments.

The consultants reported that in most respects both departments have responded quickly to the legislative directives in the 1990 study. A new interagency task force serves as a forum for issues of concern to both departments and seems to be operating effectively. Better communication has helped the departments move on such matters as determining eligibility and processing enrollment in the new state health insurance program and Medicaid.

More children are now eligible for Medicaid, and enrollment is up. Progress has also been made in billing for mental health services, covering case management services, and in identifying and addressing common issues between the new state health insurance program and Medicaid.

In some areas the departments have not made comparable progress. Billing for the services of other health programs (besides mental health) has been slow, and the Department of Human Services has rejected the legislative directive to raise clinic reimbursement rates to cover providers' actual costs. The departments have not yet established a formal way to communicate with outside groups in developing Medicaid programs, creating a special form for Medicaid applicants, expanding eligibility to 133 percent of the payment standard, and expanding coverage in such areas as occupational and physical therapy in the schools.

Recommendations

The consultants believe that there is a continuing need for an action plan that sets forth what must be done to accomplish each recommendation. The action plan would guide the task force in establishing goals, specific steps, responsibilities, time lines, and target dates for efforts to maximize federal revenues.

Background

Medicaid is a federal and state program of health care coverage for certain low-income groups. It provides federal matching funds to states that qualify. For services covered in Hawaii, the federal match comes to about 54 percent of total costs. Hawaii's program is administered by the Department of Human Services.

Because the Medicaid program has some flexibility, the Legislature thought it possible that Hawaii may be funding services that could be eligible for federal matching funds. The Legislature in 1989 requested the auditor to study this issue and to recommend a plan for maximizing what the State could gain in federal funds. The study, prepared by two consulting firms, Lewin/ICF and Fox Health Policy Consultants, examined how the state could expand coverage and services and how the Departments of Health and Human Services could better administer the Medicaid program.

The consultants found that the State could realize $2 million or more in additional federal Medicaid funds by broadening coverage and improving policies and procedures for reimbursements. Although the state program included most eligibility categories, it could adopt still others. Finally, both departments could make administrative improvements, particularly in interdepartmental coordination and data management. The consultants incorporated their recommendations in a strategic plan that set forth, with suggested time frames, the actions that had to be taken to implement the recommendations. Both departments agreed in general with the recommendations made by the consultants.

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THE AUDITOR
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Report No. 91-3
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Foreword

The 1990 Legislature passed a series of bills and resolutions requesting that the Department of Health and the Department of Human Services develop and implement a strategic plan for maximizing federal Medicaid dollars. The measures were based on recommendations in the *Study and Plan for Maximizing Federal Medicaid Funds for Hawaii* prepared by Lewin/ICF and Fox Health Policy Consultants for the Office of the Auditor. One of the resolutions, House Concurrent Resolution 140, H.D. 1, S.D.1, requested that the two departments submit for the auditor's review and comment a report on their progress in implementing the recommendations in the study.

We asked Lewin/ICF and Fox Health Policy Consultants to review and comment on the progress report. We join the consultants in expressing our appreciation to the Department of Health and the Department of Human Services for their cooperation and assistance.

Newton Sue
Acting Auditor
State of Hawaii

January 1991

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Review of the Progress Report on Maximizing Federal Medicaid Funds for Hawaii

This report contains our assessment of progress made by the Department of Human Services and the Department of Health in implementing the recommendations in the *Study and Plan for Maximizing Federal Medicaid Funds for Hawaii*, a report we prepared for the Office of the Auditor. The assessment is based on the progress report submitted by the Department of Health (DOH) and the Department of Human Services (DHS), related documentation, and a series of approximately 18 telephone interviews conducted with key personnel in the two departments. The complete text of the progress report is in the appendix.

Given the tight time frame for reviewing the progress report, we acknowledge our assessment was a limited one. The full range of interviews and data analysis that would be necessary to assess the departments' progress was not possible. We are confident, however, about the general thrust and direction of our findings. The specifics may be viewed as tentative in nature.

We conclude overall that both DOH and DHS have responded quickly to the legislative directives resulting from the 1990 study. Efforts to improve communication between the two departments seem to have been effective in facilitating coordination on several common issues, such as eligibility for and enrollment in the State health insurance program (SHIP) and Medicaid. However, there are a number of areas, such as reimbursement for certain types of services, in which actions have been slower. In still others, there appears to have been little movement. There also appears to be a continuing need for an action plan that can guide the departments in establishing goals, specific steps, assigned responsibilities, time lines, and target dates for efforts to maximize federal revenues.

The following sections provide:

- An overview of the legislative measures relating to maximizing federal Medicaid funds
- Summary of progress made by DOH and DHS
- Factors that affect progress, and
- Conclusions

Overview of Legislative Measures

Direction for the effort to maximize federal Medicaid funding came from four legislative measures. These measures incorporated recommendations from the auditor's study. First, Act 202 of 1990 required DHS to:

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

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

3. Expand the State's Medicaid definition of rehabilitation services to permit coverage of mental health services to students with emotional problems and to adults with severe emotional disabilities.

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

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

6. Increase the State's Medicaid reimbursement rate for clinic services to reflect the actual service costs of providers.

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

Second, House Concurrent Resolution Number 139 required that an interagency task force be formed to help DOH and DHS "effect interdepartmental communication and coordination on efforts to expand federal Medicaid dollars and other state health initiatives involving the two departments." The resolution said that an interagency task force would be:

> The best way to (a) encourage a new sense of mission in DHS and DOH; (b) ensure coordination between the two agencies and among key divisions within the agencies; and (c) ensure sustained attention and action on the range of areas where program development will be critical, especially eligibility and enrollment expansions, benefit and billing changes within DOH, the

implementation of the State Health Insurance Program (SHIP), and consideration/assessment of new federal eligibility options or development of initiatives.

The interagency task force was to identify and correct communication problems between the two departments; identify issues in assessing Medicaid options and the data needed to do it; examine the recommendations in the auditor's report and establish a detailed plan for implementation; identify other state health policy issues and develop a plan for interdepartmental collaboration.

The third legislative measure, House Concurrent Resolution 148, requested that the DHS shorten the application form for Medicaid (and for food stamps) as a way of enhancing access to the program.

Finally, House Concurrent Resolution 140 (H.D. 1, S.D. 1) requested DHS and DOH to submit a progress report on the above efforts and further clarified that the interagency task force efforts should be aimed at:

1. Broadening Medicaid coverage and improving policies and procedures for federal reimbursement.

2. Coordinating matters related to Medicaid through the mutual establishment of a process which will ensure effective, consistent, and ongoing interdepartmental communication and coordination, including, but not limited to, the identification and exchange of needed information between departments.

3. Opening the administrative processes of the departments to input from interested community groups, including providers and advocate groups.

4. Developing more effective information systems for monitoring, assessing, and implementing Medicaid options and coverage.

5. Establishing within each department at least one staff position to act as the designated focal point for monitoring, assessing, developing, and implementing the plan.

6. Identifying other state health policy issues and programs requiring coordination between the two departments, including the state health insurance program, and developing plans and mechanisms for interdepartmental collaboration.

Summary of Progress

An interagency task force was formed soon after the measures were passed, and the two departments have moved relatively quickly to pursue several of the recommendations from the auditor's report. Progress has been slow in some areas, however, and some areas of activity have not yet been initiated. This section summarizes our understanding of (1) where progress has been made, (2) where progress has been slow, and (3) where progress has not yet been made.

Where progress has been made

Both DOH and DHS have apparently made good headway in working together to ensure clear communication with each other. The improved communication and coordination appear to have contributed substantially to improvements in responses from one department to the other. In addition, DHS and DOH have taken the initiative to proceed as quickly as possible to expand eligibility and enrollment to increase the level of federal funds. Following are specific examples of how the departments are moving forward.

Creation of an interagency task force

An Interagency Task Force, comprised of administrators from DHS' Health Care Administration Division and DOH divisions, was formed shortly after the Legislature passed a resolution calling for establishment of the task force. The task force has been meeting monthly, and its recent progress report in implementing the recommendations from the 1990 auditor's study indicates that the task force is operating effectively and is serving as a forum for discussing and addressing issues and concerns of both departments. The DHS and DOH liaisons to the task force together act as a single point of contact for other department staff involved in efforts to maximize federal dollars. The liaisons appear to work well together in monitoring the implementation of strategic plan components and reporting back to the task force.

Coordination with SHIP

The joint DOH/DHS initiative to identify and address common issues between SHIP and Medicaid is noteworthy. Efforts to coordinate eligibility determination and enrollment activities between the two programs are reported to be well under way. An internal task force of SHIP administrators and DHS' Family and Adult Services Division staff appears to be identifying potential eligibility and enrollment problems in the two programs and developing the appropriate response. This includes developing an electronic interface for automatic referrals and keeping SHIP and Medicaid eligibility workers informed of the eligibility requirements for each program.

Expanded eligibility

The state implemented program expansions to children between ages four to eight below the proverty level. To facilitate this expansion, DOH agreed to transfer SHIP funds to DHS to finance coverage for these children for the first six months of 1990. At the conclusion of the auditor's study, the federal government mandated coverage of children up to age six that are below 133 percent of the poverty level. This mandated expansion has also been implemented.

Enhanced enrollment

DHS reports that it has undertaken a number of efforts to improve enrollment in the Medicaid program. The department recently initiated a pilot project with Queens Medical Center to have a DHS income maintenance worker stationed there full-time to process Medicaid applications. The worker is reportedly bringing in 100 cases per month. DHS also reports that it is developing a core of volunteers trained to help Medicaid applicants complete the application form. DHS received appropriations for two coordinator positions to recruit volunteers.

The Department also reports that it is continuing outreach to attract qualified presumptive eligibility providers. These are providers who can temporarily register pregnant women for Medicaid while DHS formally confirms and processes their eligibility status. The state now has 11 qualified presumptive eligibility providers, an increase from 6 when the 1990 study was issued. Current efforts include encouraging provider interest at briefings for obstetricians and gynecologists on the increased reimbursement rates for obstetrical and perinatal care.

Billing for mental health services

The Community Mental Health Centers (CMHCs), operating under the auspices of the Adult Mental Health and Children and Adolescent Mental Health Divisions, began submitting Medicaid claims for covered services in October. CMHC staff attended training sessions on billing procedures offered through DHS and presented by HMSA. The divisions report that they are revising the performance criteria for CMHC directors to incorporate measurable progress in third-party billings.

Targeted case management coverage for severely disabled mentally ill, developmentally disabled, medically complex, and other high-risk groups

The departments report that a state plan amendment to establish coverage of targeted case management services for the developmentally disabled has been developed and soon will be

submitted for federal approval. Two additional targeted case management amendments--one for the severely disabled mentally ill and one for children ages birth to three who are developmentally delayed or at risk for developmental delay--have been developed and are being reviewed by DHS. It is expected that they will be submitted for federal approval during the next several months.

Where progress has been slow

In several areas, progress in implementing the legislative initiatives seems to be lagging. However, it is important to recognize that an appropriate time frame for implementing these activities is not always clear. Nevertheless, DOH and DHS both have encountered several obstacles in following these directives.

Billing for reimbursable services by non-mental health programs

Improvement in billing for covered services by programs other than the mental health division apparently has been minimal. The Maternal and Child Health Branch and the Children With Special Needs Branch have apparently not taken steps to increase their Medicaid claims, although Maternal and Child Health Branch staff did attend an HMSA training session on billing procedures. Slow progress in billing by these programs may be due, in part, to the perception that billing Medicaid is not cost-effective when reimbursement rates are so low.

Reimbursements to cover providers' actual service costs

DHS has rejected the legislative directive to raise clinic reimbursement rates to cover providers' actual service costs. All clinic reimbursement rates are reportedly being reexamined, however, and several DOH programs have negotiated, or are negotiating, revised fee schedules for their clinic services.

The Maternal and Child Health Branch has negotiated enhanced reimbursement for prenatal care in response to a federal mandate. It also has submitted a revised fee schedule for family planning clinic services, which has not yet received DHS approval. The Behavioral Health Services Administration reports that it has submitted a revised fee schedule for community mental health services, which also has not yet been approved by DHS.

Outstationed eligibility workers

Other than the pilot position at Queens Medical Center, DHS has not yet stationed eligibility workers at outside service centers. The Family and Adult Services Division continues to be interested in this area, but reports that it has been stymied by lack of available staff.

Where progress has not yet been made

There are a number of areas which have not yet been addressed by either department. In some instances, it is not clear why no action has been taken; several of these areas may be lower priorities for the departments at this time and may be scheduled for future attention.

Communication with external groups

It appears that no formal mechanisms have been established to improve input from and communication with outside groups in developing Medicaid programs and policies. Task force members, however, have indicated an interest in pursuing this area. There have been a few efforts recently, notably the Family and Adult Services Division's effort to include community agencies on a task force to develop the Medicaid-only short form, and the recent joint DOH/ DHS briefing of providers on the activity of the interagency task force.

Development of Medicaid-only short form

DHS uses an integrated application form for three income maintenance programs: food stamps, financial assistance, and medical assistance. Our study recommended that DHS develop a shorter form for Medicaid applications only. DHS recently submitted a report to the Legislature on its efforts to shorten the form for Medicaid applications. The report describes DHS' analysis of the implications of a Medicaid-only application form and relates DHS' conclusion that an integrated form is most appropriate for meeting the needs of DHS clients.

DHS has substantially reduced the length of the integrated form to about one-half of the original; however, we would recommend that it consider an even shorter form. As noted in the 1990 report, the integrated form may be a deterrent to persons interested in medical assistance only. The number of these persons is likely to increase as income eligibility levels for Medicaid rise above poverty level, making many Medicaid recipients ineligible for food stamps and cash assistance.

Expanded eligibility

While the recommended Medicaid expansions for children from birth to age eight have been implemented, the expansion of the income eligibility level to 133 percent of the AFDC payment standard has not yet been funded. Reports from DHS seem to indicate that appropriations for the expansion are not being pursued by the department at this time.

Coverage for occupational therapy and physical therapy provided in schools

Until very recently, DHS had agreed to reimburse occupational therapy and physical therapy services furnished by the DOH School Health Services Branch to Medicaid-enrolled special education students, but *only* if all children receiving these services were billed. The School Health Services Branch was not prepared to institute universal billing for reasons related to federal education policy which prohibits billing parents for services to handicapped children.

Rehabilitative services coverage for mental health services to severely emotionally disturbed students

Our interviews revealed that, until very recently, the Task Force has apparently not attempted to expand the rehabilitative services benefit to include services for severely emotionally disturbed students.

Rehabilitative services coverage for mental health services to the severely disabled mentally ill

Again, only very recently has the Task Force begun to consider the issue of expanding the rehabilitative services benefit to include services for the severely disabled mentally ill.

Other licensed-practitioner services coverage for public health nurses

From what we have been able to learn, revision of the Other Licensed Practitioner Benefit to permit reimbursement of certain public health nursing activities has not yet been undertaken. In this area too, the DOH branch chief was apparently asked only recently by the Task Force to develop a proposed benefit change.

Factors Accounting for Slow or Unclear Progress

Our information about the process of implementing the legislative mandates suggests that delays in the Task Force's progress can be attributed to a variety of factors. We have grouped these factors as follows:

- Insufficient time
- Insufficient resources
- Uneven commitment to implementing recommendations in the auditor's study
- Lack of accurate information
- Lack of an action plan

Insufficient time

The Legislature has requested much of the two departments, and some of the slow progress is because many of these activities take time to initiate and complete. New Medicaid programs and policies and policy changes often require major administrative efforts. Start-up time may seem slow, while administrative and implementation details are confirmed and new processes are debugged. For example, making benefit and reimbursement changes requires writing rules, holding hearings, and several other steps before the changes become effective.

In addition, responding to the recommendations in the 1990 study may not be a priority for DOH at this time. The department has been focusing on implementing SHIP and helping move Hawaii towards universal health care coverage. As SHIP becomes better established, DOH may pay more attention to billing issues. Billing becomes a more critical issue when more people in Hawaii become insured.

Insufficient resources

Some DHS efforts to respond to the 1990 study recommendations have been inhibited by a shortage of funds. For example, DHS interest in improving Medicaid enrollment by stationing eligibility workers in outside facilities has faltered for lack of available personnel and lack of funding for additional eligibility workers. The proposed eligibility expansion for the medically needy has not occurred because no appropriation was made to fund that effort. The extent to which these efforts can be realized may depend in large part on future allocation of funds for these purposes.

Uneven commitment to implementing recommendations in the auditor's study

Commitment to implementing the legislative mandates could be strengthened. Perhaps not all of the staff involved in the process are giving high priority to the Medicaid expansion philosophy. In some instances, there appears to be a lack of urgency about implementation. Some DOH proposals for new benefits, for example, have been allowed to fall through the cracks, resulting in lost time.

Fuller discussion about the recommendations with staff could help them understand the rationale for the recommendations and the improvements that could occur. These discussions could foster better cooperation and commitment to making changes in the program.

It seems also that there is not a full understanding of the cost-saving rationale behind the study's recommendations for cost-based reimbursement of DOH's public and private providers. A better appreciation of how this strategy of differential payments serves to increase federal Medicaid revenues without expending new state dollars might have resulted in a more extensive analytical discussion of the issue among Task Force members. From the limited

information available to us, it appears that the group rejected the concept of a "two-tiered" reimbursement system out-of-hand. (A system where private providers are paid a reasonable percentage of their usual and customary fee, and DOH-contracted providers are paid near cost.) The substantial implications of such a rejection appear not to have been fully considered. Most importantly, it seems that no attention was given to the financial implications of implementing the recommendations for new or expanded benefits under a single reimbursement-rate system.

Lack of accurate information

Another factor that has hampered implementation of the legislative directives is the incomplete or inaccurate Medicaid information received by Task Force members. One area of confusion has been the availability of Medicaid reimbursement for administrative costs. Unfortunately, Task Force members have been told that it is not possible to claim reimbursement for administrative costs associated with Medicaid billing, except as these costs are linked to participating in the Medicaid Management Information System. While it is true that the Medicaid program may not directly reimburse for these costs, it does permit service reimbursement rates to reflect a provider's administrative overhead. Such overhead costs could include accountant, clerk, and other office expenses related to the operation of a billing system.

Another area of confusion has apparently been whether the Medicaid program can provide reimbursement for services that are otherwise available free--that is, services for which non-Medicaid recipients are not billed. We understand that the School Health Services Branch had, until very recently, been informed that the Medicaid program could not be billed unless all children receiving ancillary therapies were billed for services. This halted progress on billing for school health services.

The information was correct in that it represents the basic philosophy of the Medicaid program. It ignores, however, the exceptions that the Health Care Financing Administration has made in situations where state and local grant funds are available (See Legislative Auditor's Report, page 19). More importantly, a very recent General Counsel's Opinion from the federal Health Care Financing Administration clarifies that Medicaid reimbursement is available for health-related services to special education recipients even where other children are not billed.

There has also been some confusion about Medicaid reimbursement for services funded by Title V. Apparently it is not well understood that, under federal regulation (42 C.F.R. 431.615), Title V programs and providers must be paid at their actual service cost if they request cost-related reimbursement from their Medicaid agency.

Lack of an action plan

The remaining factor that appears to have inhibited progress is that the Task Force has not developed a detailed, integrated action plan for implementing the legislative mandates. Because of this, progress has been piecemeal across DOH programs. Moreover, there has been some duplication of effort as each program works to solve the various record-keeping and other problems associated with instituting third-party billing.

The basic issue of whether DOH will develop a department-wide billing system also has not been resolved. As we understand it, some branches and divisions are far ahead of others in their capacity to bill. There appears to have been no consideration of the data and cost implications of having different approaches to submitting and tracking claims within the department. If the department does not plan to have a department-wide billing system, it may need to give attention to how it will assist "novice" billers.

Most importantly, from what we have been able to learn, there has been no policy decision about whether DOH programs should have access to some portion of the Medicaid revenues they receive. Some DOH branches and divisions have a stake in rapidly expanding Medicaid billings because special funds have been established to give them some or all of the federal funds they collect.

Conclusions

In general, we found that the Task Force has made much progress, but that it could benefit substantially from a detailed, integrated action plan, setting forth what must be accomplished to move forward on each recommendation. The plan could identify areas where basic threshold decisions by departments need to be made. It also could identify steps that each program chief will need to take to implement the recommendations, including both state plan amendment development and operational changes. The plan could include an assessment of the knowledge base within the two departments, and indicate where outside consultant expertise would be useful.

All of this planning, however, needs to be carried out within the context of Hawaii's new health care financing system. As the state moves ahead in the health insurance arena to become a universal access state, the role of DOH programs is, of necessity, in transition. The department will be evolving from programs serving the uninsured to programs providing specialized or otherwise unavailable services to individuals who have some health insurance protection. Because of this, the branches and divisions need to recast their missions as those responsible for providers who furnish units of service, track their time, code their interventions, and bill third party payers.

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EXECUTIVE CHAMBERS
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JOHN WAIHEE
GOVERNOR

November 20, 1990

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

Dear Mr. Sue:

Transmitted herewith is a copy of the Report on Maximizing Federal Medicaid Funds for Hawaii prepared by the Department of Human Services and the Department of Health, pursuant to House Concurrent Resolution No. 140.

With kindest regards,

Sincerely,

JOHN WAIHEE

Enclosure

PROGRESS REPORT
ON MAXIMIZING FEDERAL MEDICAID
FUNDS FOR HAWAII

A Report to the Legislative Auditor

Submitted by

Department of Human Services

and

Department of Health
State of Hawaii

November, 1990

This is a joint report by the Department of Health (DOH) and the Department of Human Services (DHS) in response to the directive of the Hawaii State Legislature during its 1990 Regular Session. House Concurrent Resolution No. 140 required both departments to update the Legislative Auditor on progress in implementing the recommendations of the Lewin/ICF and Fox Health Policy Consultants' Study and Plan for Maximizing Federal Medicaid Funds for Hawaii.

OVERVIEW AND BACKGROUND

As an initial step to ensure and improve coordination between the two departments as well as among the various divisions within the agencies, staff persons have been designated as central communication points for each department. This has resulted in an improved, more clearly focused and well directed coordination and working relationship between DOH and DHS, as both departments work toward meeting the mutual objectives and responsibilities of expanding the utilization of federal Medicaid dollars, also as this relates to other state health initiatives involving both departments.

A key coordinating activity has been the formation of the DOH and the DHS interagency task force. This task force has been meeting every third Tuesday of the month since June, 1990. Monthly meetings will continue to be held until the start of the 1991 Legislative Session, during which bimonthly meetings have been planned.

The interagency task force has reviewed the recommendations incorporated into a Strategic Plan for maximizing Medicaid funding as well as the suggested time frames indicated in the study. The task force views this activity as an evolving process and is continually assessing what course of action is realistic and feasible; identifying, exploring and pursuing areas of cooperation; and implementing and monitoring those recommendations and strategic plan action steps that are determined to be workable.

The following priority activities were agreed upon by the task force:

1. Start the process of education, communication and ongoing relevant exchange of information between the two departments.

2. Ensure that priority activities and recommendations under the areas of action in the state Medicaid program: Benefit and Billing Options; Eligibility and Enrollment Expansions and Modifications; and Administrative Changes, in particular, those that are specifically stated in Act 202, are initiated and carried out. It was the consensus of the task force that the most critical issue that needed to be addressed was for DOH providers to bill Medicaid for services that are already reimbursable.

3. Develop a more detailed plan of action for mutual implementation, as well as long term goals when priority goals and activities are accomplished and after a further in-depth assessment and more thorough and extensive review of the actual situation and the steps in the Strategic Plan.

4. Outline achievable goals and timelines. After a careful examination of the recommendations presented in the study, priority issues and areas, including responsibilities, were identified for implementation before the end of 1990.

TASK FORCE GOALS

As a strategy toward achieving the priority activities outlined above, the task force established five goals for the period from July through December, 1990:

A. **Increased Interagency Communication.**

--- Communication between the agencies has been facilitated through the designation of specific DOH and DHS staff as conduits of information. Regular meetings of the task force serve as a forum for exchanging information and following up on issues of mutual concern.

--- Topics for information sharing and coordinated planning include those issues raised in the Lewin/ICF/Fox report, in addition to recent federal mandates, other Medicaid-related issues, and SHIP.

B. **Increased Billing for Existing Medicaid Reimbursable Services by December, 1990.**

--- Key DOH staff members, particularly from the Behavioral Health Services Administration (BHSA), have attended provider training sessions conducted by HMSA. All mental health centers were billing for Medicaid services by October 1st and will bill for other third party payment by the end of 1990. Further training sessions will be scheduled as additional DOH billing systems become operational.

--- The DOH began a review of existing Medicaid provider numbers to check for appropriateness. This review is still ongoing but has revealed the need for very few changes. The DOH plans to review provider numbers on an annual basis.

C. **Creation of Targeted Case Management Benefit.**

--- Work has been done by DHS/HCAD staff and DOH staff in the Developmental Disabilities (DD) Division, BHSA, and the Family Health Services Division's Zero-to-Three Early Intervention

Project to prepare amendments to the state Medicaid plan creating targeted case management for the respective programs as a covered service.

--- The State plan amendment for the DD/Mentally Retarded benefit is being finalized for submission to the Health Care Financing Administration (HCFA). It is anticipated that administrative rules will be adopted for this benefit by the second quarter of 1991. When this first State plan amendment is completed and approved, it will serve as the model State plan for the other new benefits. The State plan amendments for the Seriously Disabled Mentally Ill and Zero-to-Three programs are also being developed and it is anticipated that administrative rules for these benefits will be adopted during the third quarter of 1991.

D. **Initiate State Plans for Additional Benefits.**

--- DOH staff in PHSA and BHSA have been asked to prepare first drafts of the State plan amendments for the remaining Lewin/ICF/Fox report recommendations for DOH programs by December, 1990.

E. **Update and Solicit Inputs from Interested Individuals and Organizations in the Community.**

--- A public briefing on progress toward the report's recommendations has been scheduled for December, 1990.

COMMUNICATION TOPICS AND ISSUES

Through the departmental staff persons and the interagency task force, a number of Medicaid-related issues, including the following, have been addressed and discussed:

A. <u>OBRA 89 and Related Issues</u>

The DHS has been updating the DOH on the status of the following OBRA 89 and related issues:

1. **Payment for Obstetric and Pediatric Services and the Perinatal Demonstration Project** --- The State plan amendment relating to payment levels for obstetric and pediatric services has been approved by HCFA. To further assure adequate reimbursement and quality of perinatal care, as well as access to services, the State Legislature authorized a demonstration project to provide increased flat rate reimbursement ($900 for vaginal birth and $1,400 for caesarian section) to physicians and certified nurse-midwives for obstetrical and perinatal care. This demonstration project was launched on November 1, 1990 and is progressing smoothly.

2. **Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)** --- HCAD is developing a periodicity schedule for dental services and is coordinating with its Medicaid Management Information System (MMIS) to meet the reporting requirements of this provision.

3. **Required Coverage of Nurse Practitioner Services** --- HCAD is working with the Department of Commerce and Consumer Affairs, Board of Nursing, to establish mechanisms in order for Medicaid to be able to reimburse nurse practitioners.

4. **Payment for Federally Qualified Health Center (FQHC) Services** --- The State plan amendment relating to FQHCs was submitted to HCFA for their review and approval in September, 1990.

B. <u>Eligibility and Expansion Issues</u>

1. **Development of a "short form" for Medicaid Applications** --- A shortened application form is currently being developed by a task force composed of the Family and Adult Services Division (FASD)/ DHS; the Hawaii Community Action Program; and the Legal Aid Society. As with the current 44-page form, this shortened form will likewise include applications for Medicaid, Financial Assistance and Food Stamps. The task force will submit a report to the Legislature in January 1991. There is a plan to experiment on the use of this "short form" for an initial period of six to twelve months. The "short form" could also go into a second phase with the development of a Medicaid-only form for applicants needing long term care, if determined to be feasible.

2. **Placement of Outstationed Workers** --- The DHS is currently collaborating with The Queens Medical Center on a pilot project which teams a full-time DHS Income Maintenance Worker (IMW) with the hospital's Patient Representatives. The IMW is outstationed at Queen's Hospital and processes applications from referrals made by the Patient Representatives. This project has resulted in an average of 85 Medicaid applications per month, with 60 to 75 per cent determined eligible. A project evaluation will be conducted in January 1991.

Recognizing the tremendous impact of outstationing workers to increase access to the Medicaid program, the DOH, through the interagency task force, is exploring tapping the Public Health Nurses, beginning with those interested in Molokai, to assist with efforts to enhance Medicaid enrollment and increase applications where there is a critical need. The DHS is also developing a core of volunteers who will be trained in assisting applicants complete their application form. The 1990 Legislature approved Volunteer Service Coordinator positions (two in Oahu; two on the Big Island; one in Maui; and one in Kauai).

3. **Coordination of SHIP with Medicaid** --- There is excellent coordination between the SHIP program and Medicaid in maximizing Medicaid benefits and in enrolling non-Medicaid eligibles in the SHIP program.

A Program Development-Medical Assistance (PD-MA) staff in FASD/DHS is assigned the SHIP/Medicaid Coordinating task. This SHIP Coordinator within DHS has worked closely with the SHIP Office since March this year and has conducted statewide orientations to DOH Certified SHIP Registrants and Public Health Nurses as well as DHS IMWs.

The IMW staff are regularly informed of guidelines for SHIP referral. Since the orientation, they have been informing applicants who are determined to be ineligible or who are terminated from the Medicaid program about potential SHIP coverage. Referral works the other way also in that clients who apply for SHIP coverage but could qualify for Medicaid are referred to the IMWs. In an effort to improve this referral process, an integrated electronic interface between Medicaid and SHIP was developed and implemented effective October 1, 1990. A Memorandum of Agreement which involves modifications to Medicaid's HAWI system to facilitate application will be executed before the end of 1990.

As of August, 1990 the DOH received 5,535 SHIP applications from all sources. Data on the number of referrals from DHS is being compiled for planning purposes. However, according to the DOH SHIP Coordinator, the actual number of DHS referrals to the SHIP program is currently unavailable.

The task force is also exploring possibilities to enhance interface referral procedures for pregnant women who qualify for the liberal 185% federal poverty level Medicaid eligibility limit in order to provide them with more comprehensive Medicaid coverage under the MOMI program.

In addition, through an agreement implementing the expansion of Medicaid services to children 4 - 7 years of age up to poverty level, SHIP transferred funds to DHS to cover services rendered between January through June, 1990. A total of 722 children were served with Medicaid reimbursement of $944,495.23, with federal share amounting to $574,750.00.

4. **Recruiting Providers Certified to Determine Presumptive Eligibility** --- There are six qualified presumptive eligibility providers on Oahu; one on Hilo; one on Kohala; one on Kauai; and one on Molokai. Outreach activities are ongoing and there are continued efforts to recruit more providers qualified to enroll pregnant women on an early and preliminary basis. There is also a strong possibility of recruiting more providers on Maui and on the other islands as the perinatal demonstration project gets underway.

5. **Increased Enrollment of Persons Certified for Medicaid-only Eligibility** --- The Medicaid-Only Pregnant Women and Infants (MOMI) initiative expanded the coverage of the Medicaid-only population: pregnant women and infants at 185 percent of the poverty level; children aged 1 - 6 at 133 percent of poverty; and children aged 7 - under 8 at 100 percent of poverty. This initiative became effective on April 1, 1990. DHS data shows an increase in these cases from 674 in March, 1990 to 1,064 in September, 1990.

C. **Analysis of the Reimbursement Methodology System**

HCAD/DHS is currently doing a general analysis of reimbursement rates for all clinics. A more systematic and equitable rate setting and reimbursement methodology for all clinics will be developed as a result of this analysis.

Legislation to increase physician reimbursement rates from 56 percent to 65 percent of the customary rates is being considered.

CONCLUSION

The interagency task force will continue to be the focal point and key coordinating body for addressing Medicaid issues. Both the DOH and the DHS are continually working to:

- Achieve close communication, coordination and cooperation within their departments, with each other, and with community groups.

- Explore other major areas for enhancing Medicaid opportunities.

- Review existing information systems and analyze their capacity to effectively assess, monitor and evaluate Medicaid options and the overall extent of Medicaid coverage in Hawaii.

There is definitely a strong consensus among the leadership of the DOH and the DHS to take on the major challenge of improving interdepartmental coordination and committing staff time and other resources in their efforts to maximize federal dollars in Hawaii's health programs. Both departments recognize that there are still a lot of things that need to be accomplished and they are enthusiastically and vigorously collaborating to respond to the challenge of maximizing federal reimbursement, as well as pursuing other state health initiatives.

A joint report about this activity, which would include the highlights of the December, 1990 public briefing, will be submitted to the Legislature pursuant to Senate Concurrent Resolution No. 130.

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