
Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project

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

Report No. 03-07
May 2003



THE AUDITOR
STATE OF HAWAII

Office of the Auditor

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THE AUDITOR

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OVERVIEW

Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project

Report No. 03-07, May 2003

Summary

In 1994 the Department of Human Services implemented the QUEST Demonstration Project, a federally approved Section 1115 Medicaid waiver project, to demonstrate the efficacy of a managed care approach for state-funded health care services. QUEST initially incorporated health care services for the Aid to Families with Dependent Children (now known as Temporary Assistance to Needy Families), General Assistance, and State Health Insurance Program. Health care for a portion of the aged, blind, and disabled population was to be incorporated as the second of several phased expansions of the QUEST project.

However, an audit conducted by our office in 1996 found that the project had been inadequately planned and hastily implemented, resulting in management problems and the inability to substantiate its effectiveness and efficiency claims. We recommended that these concerns be resolved before implementation of any planned program expansions.

This audit follows up on the recommendations from the 1996 audit and several subsequent audits that examined various aspects of the QUEST Demonstration Project. We found that QUEST continues to experience problems from inadequate planning and design that hamper the development and expansion of a managed care approach to health care. After nine years, enrollment and participation in QUEST are basically unchanged and planning efforts to incorporate the aged, blind, and disabled population have ceased.

QUEST has been keeping project costs under control, with the average annual cost per enrollee remaining less than \$2,000 between waiver years 1998 and 2001. This cost rose to \$2,068 for waiver year 2002; however, this was still less than the 1997 cost of \$2,090, for example. In addition, federal budget limits, which are based on the cumulative total of expenditures over the life of the project, have been adhered to since 2001. However, in view of rising health care costs nationally, QUEST's ability to continue to contain costs without reducing levels of services is questionable. In addition, QUEST has not included the aged, blind, and disabled population to date, and is therefore unable to demonstrate whether the managed care approach is viable for the larger range of patients.

We also found that while the department's Med-QUEST Division has overcome some operational weaknesses, other management control and staffing problems still hamper QUEST's operations. Self-declaration and presumptive eligibility practices have reduced the application backlog but also increased the likelihood that ineligible applicants may receive benefits. There continue to be problems with the eligibility review process, with case file records that lack proper documentation that eligibility has been reviewed, and are incomplete and inconsistent. Some management control problems appear to be associated with the staffing concerns identified in our 1996 audit. For example, the backlog of eligibility reviews appears proportional to



caseload. The Oahu office, with the highest caseload per staff member, has the most incomplete case files. We found 88 of the 187 Oahu case files we sampled (47 percent) lacked adequate documentation of eligibility reviews. The East Hawaii, West Hawaii, Kauai, and Molokai offices were generally up to date. The Maui office was second to the Oahu office in lacking a current eligibility review, although case-worker assignments vary with the experience and classification of the case worker. The supervisor reported a shortage of personnel. We also found that the Med-QUEST Division still lacks a standard procedures manual to guide its operations.

Finally, we found that, although it has taken six years, a management information system (MIS) has finally been implemented. MIS development efforts underway during our 1996 audit failed. In 1999, Hawaii entered into a development partnership with the Arizona Health Care Cost Containment Systems Administration (AHCCCS) to jointly develop the Hawaii Arizona Prepaid Medicaid Management Information System (HAPA). Arizona, which operates the only federally certified Medicaid MIS, modified the system to satisfy the Medicaid requirements for both states.

Recommendations and Response

We recommended that the Department of Human Services evaluate the time and resources (human, financial, and physical) necessary to continue and/or expand the QUEST demonstration project. If such an evaluation favors continuation of managed care, the department should seek statutory authority to make the project permanent.

We also recommended that the department adopt an operating procedures manual to include both standard procedures for processing QUEST eligibility applications as well as procedures for cases transferred from other departmental divisions.

Finally, we recommended the department evaluate HAPA to assess the efficacy of shared technology in fulfilling information system requirements.

The Department of Human Services responded that it generally agrees with our recommendations. However, the department noted that the State is unable to seek state statutory authority to make QUEST permanent. We are aware of the federal statutory requirements for QUEST and note that our recommendations are not meant to be limited to state-level actions. For example, the National Conference of State Legislatures supports federal statutory changes that would permit successful Medicaid waiver programs to be continued by statutory authority, thereby ending the requirement to seek renewal of the demonstration authority. Given the substantial state resources invested in QUEST, we believe it is reasonable to support such federal-level actions, if the State determines that QUEST should be considered permanent. The department also provided comments to clarify statements made in the report, some of which we incorporated.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 03-07
May 2003

Foreword

This is a report of our follow-up audit of the Department of Human Services' QUEST Demonstration Project. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

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

Marion M. Higa
State Auditor

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Chapter 1

Introduction

This follow-up audit of the QUEST Demonstration Project of the Department of Human Services was undertaken to assess the project's progress since our 1996 audit. It was conducted pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the office to conduct postaudits of the transactions, accounts, programs, and performance of all state agencies. The 1996 audit was initiated because of concerns that the Department of Human Services was experiencing difficulty in meeting the objectives of the QUEST demonstration project.

Background on the QUEST Demonstration Project

The Hawaii Health QUEST demonstration project is a federally approved Medicaid waiver project administered by the department's Med-QUEST Division. QUEST is an acronym that stands for: Quality Care, ensuring Universal Access, encouraging Efficient Utilization, Stabilizing Costs, and Transforming the way health care is provided. QUEST has two basic objectives: 1) to expand medical coverage to include populations previously ineligible for Medicaid and 2) to contain costs by shifting from a fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage.

In the absence of federal reform, states have initiated their own health care reforms, which largely focus on the Medicaid program. Medicaid reforms have expanded coverage in two ways: 1) by redefining Medicaid coverage and utilizing managed care; and 2) by utilizing "1115" waivers to include more uninsured persons and test other program changes.

Section 1115 of the Social Security Act outlines requirements for experimental, pilot, or demonstration projects and allows states to reform their Medicaid programs. It also allows the federal Secretary of Health and Human Services to waive compliance with any requirements of certain sections of statutes, including Medicaid, for any projects that would promote the objectives of the national Social Security Act.

The Social Security Act was originally established in 1935 to promote economic and social security. From early on, efforts were made to incorporate some type of national health program into the act. These efforts culminated in 1965 with the enactment of the Social Security Amendments Act of 1965 that included provisions for the establishment of the Medicaid program.

The QUEST demonstration project placed three fee-for-service Medicaid programs under a single managed care program: the Aid to Families with Dependent Children Program (AFDC, subsequently TANF – Temporary Assistance to Needy Families), the General Assistance program (GA), and the State Health Insurance Program (SHIP).

Liberal eligibility criteria set by Hawaii's Department of Human Services promoted the enrollment of persons for whom the project was not intended. Eligibility criteria in 1994 required persons to be less than 65 years of age, a citizen or legal alien not in a public institution, employed without medical insurance provisions, and earning not more than 300 percent of the Federal Poverty Level (FPL) in order to join (\$25,410 for a single person, up to \$51,060 for a family of four). Any person meeting these criteria was entitled to free or subsidized medical insurance under QUEST.

Predictably, many people who had or could afford medical insurance terminated their existing health care coverage and enrolled in the project. Those enrollees included college-aged children who were previously covered under their parents' health insurance plans; working adults who dropped employer-sponsored coverage for their dependents and enrolled them under QUEST; working adults with income levels between 62.5 percent and 133 percent of the FPL who were formerly insured through their employers; and individuals with income levels under 300 percent of the FPL but who had additional assets and could afford health insurance. The department did not anticipate or plan for the additional 13,000 to 48,000 enrollees that resulted from its liberal eligibility criteria; consequently, the number of persons who enrolled in QUEST was higher than originally estimated.

The QUEST project subsequently reduced the 300 percent FPL requirement to 200 percent of the FPL in an effort to control expanded enrollment numbers. In addition to these eligibility requirements, an enrollment cap of 125,000 members was placed upon the QUEST project in February 1996. In order for new applications to be accepted, QUEST enrollment cannot exceed 120,000 on December 31 of any calendar year preceding the open application period. The enrollment cap does not apply to those individuals who would have been eligible for Medicaid prior to the waiver. According to the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), all protected groups, such as those whose income is less than the AFDC standard of assistance or pregnant women who meet income limits, cannot be denied access to the QUEST project regardless of the enrollment cap.

In April 1996, an asset test was added as a result of a legal challenge based on the Americans with Disabilities Act. Now, individuals' personal assets as well as their income are considered when determining

eligibility. This caused some QUEST participants to become ineligible for the basic QUEST insurance. In response, the department developed a new plan called QUEST-Net to accommodate those who became ineligible because of the new asset test. The department then developed another plan, QUEST-P, for those who were ineligible for QUEST and QUEST-Net. QUEST-P was intended to be a temporary transition program and was phased out in 1997.

Today, as shown in Appendix A, the Med-QUEST Division administers at least 12 programs; however, QUEST and QUEST-Net are the only two programs operating under the QUEST Demonstration Project Section 1115 waiver. Enrollment requirements in QUEST have remained basically unchanged since these adjustments were implemented. The remaining Medicaid population—the aged, blind, and disabled—has yet to be included in the program.

Medicaid fee-for-service versus QUEST managed care

Medicaid is a fee-for-service health program for the poor that is funded by both the state and federal governments. “Fee-for-service” means that physicians and hospitals bill for each eligible service provided to a Medicaid patient. The traditional fee-for-service arrangement can be more costly than managed care because it exercises less control over patient visits, has greater potential for unnecessary medical procedures or services, and has a greater chance of claims fraud.

Managed care, on the other hand, has been defined as “a health care delivery system with a single point of entry.” Cost savings are achieved through a set monthly fee or “capitated payment” to a health plan, which assumes responsibility for any financial risk.

A primary care physician, or “provider,” participating in a managed care health care plan serves as a “gatekeeper” by deciding when a patient should be referred to a specialist or admitted to a hospital. The plan must manage the delivery of patient care at a cost covered by the plan’s capitated fees or lose money. The plan’s incentive is to maintain a balance between health care and costs by minimizing extraordinary or unnecessary expenses.

QUEST allows participants to select medical and dental plans from participating health care providers. There are currently three providers on Oahu: Kaiser, HMSA, and AlohaCare. A minimum of two providers is required on each neighbor island, but exemptions have been obtained for Molokai and Lanai since HMSA is the only provider on these islands. Dental coverage was initially covered as an option under QUEST; however, services have been reduced to emergency-only services for adults. The dental program has recently reverted to fee-for-service.

Funding for QUEST Demonstration Project

The QUEST project is financed approximately 50 percent by state general funds and 50 percent by federal funds. Federal funds are authorized and received through the Social Security Act, Title XIX of the U.S. Code. QUEST was implemented under the department's expectation that it would remain budget neutral over the course of the five-year project, a condition of the Section 1115 waiver. That is, the cost of the waiver program cannot exceed what the federal government would have spent without the program. There were initial concerns because the unanticipated, large participation in QUEST resulted in higher than projected enrollments, causing the program to exceed the federal budget neutrality requirements and escalating costs over projections. However, the program finally achieved budget neutrality in its sixth year (FY2000-01).

The QUEST Demonstration Project Intended To Expand Eligibility in Five Phases

Originally, the complete QUEST project was to have been implemented in five phases starting in 1994. Phase I combined the health care provided under Aid to Families with Dependent Children (AFDC), General Assistance (GA), and the State Health Insurance Program (SHIP) into a managed care program. Phase II, originally targeted for implementation in July 1997, would have incorporated portions of the aged, blind, and disabled (ABD) population; Phase III would have encompassed small business associations; Phase IV would have included state employees; and Phase V would have addressed workers' compensation.

In February 1997, the Med-QUEST Division contacted the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services, or CMS) to amend the 1115 waiver program to extend health care coverage to certain ABD eligibility groups. The first component of Phase II would provide medical, dental, and behavioral health benefits to Medicaid-only ABD members. The second component would incorporate long term care and home and community-based services to integrate Medicaid and Medicare. However, Phase II was eventually scaled back to include only those within the first component. Phase III was correspondingly redefined to target the remaining ABD recipients except for children. The department had targeted July 1997 for implementation of Phase II; but decided to pursue a three-year extension for Phase I and implement the information system instead. In September 1998, HCFA approved an extension of QUEST through March 31, 2002.

In February 2001 the department reported that it was again pursuing implementation of Phase II and hoped to receive approval to proceed by Summer 2001; however, on May 18, 2001 the department formally

withdrew its request to include the ABD population in QUEST, noting that the State intended to implement the provisions of the 1997 Balanced Budget Act to enroll ABD recipients into health care plans.

In July 2002, CMS approved a second three-year extension of QUEST through June 30, 2005.

Prior Audits Found QUEST Had Significant Implementation Problems

Audit of the QUEST Demonstration Project, Report No. 96-19

A number of previous audits have been conducted pertaining to the QUEST program. These include financial audits of the Department of Human Services and of the Med-QUEST Division; a management audit of the department's information system; a management audit of the department; and an audit of the QUEST Demonstration Project.

The first audit was initiated because of concerns that the Department of Human Services was experiencing difficulty in meeting the QUEST Demonstration Project's objectives. The report found that Phase I of the project had been inadequately planned and hastily implemented; lacked management controls, staff, and a required management information system (MIS) to properly administer the program; and had yet to demonstrate it was saving the State money. We also expressed concern that the federal government might require the State to revert to the traditional Medicaid program because it had not met requirements of the Health Care Financing Administration.

We recommended that Phase II be delayed until Phase I problems were resolved; sufficient resources be allocated to implement the required MIS; QUEST be separated from other Medicaid programs in future budget requests and assigned a separate budget program ID; the required eligibility and annual re-verification procedures be standardized; and sufficient staff be hired to administer the program.

Management Audit of the Department of Human Services, Report No. 97-18

This audit was conducted a year after our report on the QUEST Demonstration Project. The audit found that controls for QUEST eligibility determination had not significantly improved; annual eligibility verification processes were still weak and had substantive backlogs; the required management information system was still undeveloped; and the department lacked an effective evaluation mechanism for QUEST. After three years, QUEST's federally required encounter data had not been analyzed and the required quarterly reports had never been submitted.

We recommended that an MIS intended for a managed care system be implemented; and that evaluation procedures be incorporated in existing programs and included in new programs before implementation.

Financial Audit of the Department of Human Services, Report No. 98-14

This report found continued internal control and operational problems that affected the Med-QUEST Division and the QUEST Demonstration Project. Annual re-verification requirements were not being met; over \$5 million in clients' share of QUEST premium costs were uncollected; and the Hawaii Automated Welfare Information (HAWI) system lacked adequate data entry controls, resulting in overpayments. We recommended stronger oversight to ensure that the QUEST project collects all amounts due from its clients; and that the improvements to the existing HAWI system be made a priority.

Audit of the Department of Human Services' Information Systems, Report No. 01-05

This report found that the contractor retained to develop the QUEST information system had failed to produce a functional system. Rather than pursue litigation, the department reached a settlement with the contractor and terminated the contract. In 1999, the department contracted with the State of Arizona to modify its Prepaid Medical Management Information System (PMMIS) to accommodate Hawaii's QUEST project and replace the previously failed attempt to develop a QUEST information system. The new system, Hawaii Arizona PMMIS Alliance, or HAPA, was intended to be operational by October 2000, with Arizona maintaining the system until June 2001.

Financial Audit of the Med-QUEST Division of the Department of Human Services, Report No. 01-10

This fifth audit continued to report poor management control practices within the QUEST project. Program files lacked required documentation, certifications, and evidence of supervisory review; the backlog of eligibility applications had not been resolved; the division continued to be inconsistent in collection of reimbursements and disenrolling those who failed to pay required co-payments; and the division's oversight of capitation payment reconciliations had diminished following the transfer of reconciliation responsibility to the health plans. We recommended the enforcement of policies and procedures relevant to QUEST eligibility, re-verification, disenrollment, and delinquent receivables; and that a QUEST claims review process be established.

Objectives of the Audit

1. Review and assess the extent to which the QUEST Demonstration Project has expanded health care coverage, while realizing cost savings to the State.
2. Review and assess the extent to which previously identified management control weaknesses in the QUEST Demonstration Project have been addressed and resolved.

3. Review and report on the status of the QUEST management information system.
4. Make recommendations as appropriate.

Scope and Methodology

We focused on the findings and recommendations of Report No. 96-19, *Audit of the QUEST Demonstration Project*. We also examined four audits that pertained to the QUEST project and the Department of Human Services, concentrating on issues or concerns pertinent to QUEST.

We selected and reviewed a judgmental sample of QUEST case files at Med-QUEST Division offices on Oahu, Kauai, Maui, Molokai, East Hawaii, and West Hawaii and interviewed eligibility branch administrators and eligibility officers at each office to review process and control procedures.

We reviewed documents, reports, fiscal records, and client satisfaction reports. We met with departmental officials to identify the current status of the implementation of the HAPA (Hawaii Arizona PMMIS Alliance) information system and the continued use of the HAWI (Hawaii Automated Welfare Information) system relative to QUEST. We contacted CMS (Centers for Medicare and Medicaid Services) personnel at the regional and national levels and reviewed QUEST reports on compliance with Section 1115 waiver requirements, including budget neutrality.

Our audit was conducted between October 2002 and March 2003 in accordance with generally accepted government auditing standards (GAGAS).

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Chapter 2

Failure To Adequately Plan a Managed Health Care System Continues To Hamper the QUEST Demonstration Project

The QUEST Demonstration Project has yet to demonstrate that a managed care health system can provide quality health care while controlling costs as part of the State's goal of universal health coverage. QUEST has demonstrated the potential feasibility of a managed care approach, but the Department of Human Services' failure to adequately plan for QUEST's implementation has prevented expansion to meet project objectives.

Initially, QUEST was to incorporate all existing Medicaid recipients, including the aged, blind, and disabled (ABD) population that was to be incorporated in Phase II of the project in 1997. However, in the nine years since the QUEST Demonstration Project's inception in 1994, no progress has been made to incorporate the aged, blind, and disabled population. As a result, QUEST is still unable to demonstrate that managed care is a viable alternative for the most costly of Medicaid populations.

The Department of Human Services' Med-QUEST Division has shown some improvement in processing and maintaining accounts and in managing costs for those presently enrolled in QUEST. However, QUEST continues to experience management control and staffing problems that resulted in part from failure to properly plan for the project's implementation. These problems continue to compromise the project's operational efficiency and effectiveness. In addition, hasty implementation resulted in a failure to present a realistic assessment of the project's objectives and costs necessary to convert from a fee-for-service to a managed care system. QUEST continues to suffer from a lack of acceptance, insufficient support, and an infrastructure poorly equipped to handle the needs of a managed care health system. As a result, QUEST has yet to demonstrate the efficacy of a managed care approach to providing quality medical services to all of Hawaii's citizens.

Summary of Findings

1. The QUEST Demonstration Project continues to experience problems from inadequate planning and design, which have

hampered the development and expansion of a managed care approach to health care.

2. Procedural changes have reduced the QUEST applicant backlog and processing times. However, insufficient management controls and staffing remain a concern.
3. After Unisys failed to provide the Med-QUEST Division with its own information system, the division implemented a system based on Arizona's preexisting system six years after the project's initial start date.

Inadequate Design and Lack of Planning Continue To Hinder the QUEST Demonstration Project

Nine years after its inception, the QUEST Demonstration Project has not progressed in achieving its goal of implementing comprehensive health care reform. Rather, the Med-QUEST Division has focused on correcting operational shortcomings resulting from its rushed implementation. In an unsuccessful attempt to expand the QUEST Demonstration Project, the Department of Human Services has wasted resources by unrealistically assessing the requirements of implementing a major reform effort.

Our 1996 *Audit of the QUEST Demonstration Project*, Report No. 96-19, cited numerous problems as a result of a poorly planned and improperly supported implementation. Today, QUEST continues to experience similar problems. Corrective measures have succeeded in bringing expenditures under control; however, this has been done at the expense of providing services to all eligible participants and expanding services to other target populations as originally intended.

Enrollment and participation in the QUEST Demonstration Project is basically unchanged

Enrollment and participation in QUEST has remained relatively stable since our last audit. As we reported in 1996, the original QUEST Demonstration Project qualification requirements permitted enrollment of unanticipated classes of individuals. This resulted in over-enrollment into QUEST and expenses beyond budget. To bring QUEST expenditures under control, in 1996, the department adopted a number of constrictions to enrollment eligibility. These included a limit on QUEST enrollment to 125,000 participants, and a prohibition on open enrollment unless total enrollment dropped to 120,000 before any scheduled enrollment period. All federally protected groups—i.e., those eligible under the traditional fee-for-service Medicaid criteria—were not subject to the enrollment cap. As a result, average annual enrollment from 1997 to 2002 has remained relatively constant at approximately 129,000, effectively limiting new enrollment to federally protected groups that may not be denied access.

The Kaiser Commission on Medicaid and the Uninsured reported that between June 1997 and December 2001, Hawaii actually had a net decrease of 0.1 percent in QUEST enrollment, while total enrollment in Medicaid programs statewide increased by 2.3 percent. The commission also noted that between December 2000 and December 2001, Hawaii experienced a growth in total Medicaid participation of only 1.7 percent. During the same period, 20 states experienced double-digit increases, and another 22 states had 5 to 10 percent increases in Medicaid enrollment.

The enrollment cap, adjustments to co-pay requirements for clients qualifying under the expanded QUEST eligibility requirements, and some adjustments in services have permitted the QUEST project to operate with a relatively stable annual expenditure base. Exhibit 2.1 shows the average annual enrollment and expenditures for QUEST from 1997 – 2002.

**Exhibit 2.1
Average Enrollment and Expenditures for QUEST Demonstration Project Waiver
Year 1997 through Waiver Year 2002**

	1997	1998	1999	2000	2001	2002
Enrollment*	136,839	134,096	131,148	127,073	128,112	129,034
Program Costs**	\$286,035,307	\$257,022,904	\$254,008,534	\$253,567,158	\$252,954,004	\$266,785,201
\$/Enrollee	\$2,090	\$1,917	\$1,937	\$1,995	\$1,974	\$2,068

Note: Waiver year is from April 1 through March 31 and is the period used to calculate the Section 1115 waiver.

* Enrollment is defined as the QUEST Eligible Member Months by Month.

** Program Costs are total QUEST program costs, including all medical and dental claims, catastrophic re-insurance costs, bad debt, and FQHC payments.

Source: Department of Human Services

Unexpected enrollment results in cost overruns

The events of September 11, 2001 had a negative impact upon Hawaii’s economy, causing a number of people to lose both employment and associated medical benefits. In response, QUEST’s enrollment cap was temporarily lifted in October 2001 to allow those impacted by the events and qualified for QUEST to receive benefits.

The enrollment cap has been reinstated since mid-2002, but QUEST’s enrollment remains elevated at approximately 136,000. As a result of this unbudgeted increase in enrollment, coupled with a growth in the

capitation rate, the division now faces a budget shortfall and needs additional funding from the Legislature. However, the shortfall is not readily apparent in the division's \$309,293,699 budget request for FY2003-04, which actually reflects a decrease from the \$321,895,685 it requested in FY2002-03 (program ID HMS 245, QUEST Health Care Payments).

The division notes that its FY2002-03 QUEST budget included approximately \$64.4 million for the aged, blind, and disabled population as part of QUEST's Phase II implementation. However, following its May 2001 decision not to pursue Phase II, the division now anticipates transferring approximately \$32.1 million to the fee-for-service program (HMS 230, Health Care Payments) to cover continued payment of ABD costs. The remaining \$32.3 million will stay in HMS 245 to help absorb increased QUEST costs that resulted from increases in enrollment and the capitation rate.

QUEST's Phase II plan lacks support

The Department of Human Services has continued to pursue its goals for QUEST despite ongoing management problems and a lack of administration support for the project's expansion. In 1996, our office recommended that the department suspend its plans to implement Phase II of QUEST until it had addressed and resolved all of its problems with Phase I. Phase II, representing the aged, blind, and disabled population, presented significant management challenges in its attempt to provide necessary care in a managed care environment. Given the department's problems with QUEST, expansion to include a more complex management group into the program appeared ill-advised. The department disagreed, responding that it intended to implement Phase II in July 1997, and that failure to do so would create adverse budgetary pressures on the Medicaid programs and force reductions in services, reimbursements, and the number of eligible clients in both its fee-for-service and QUEST programs.

However, after several years of pursuing Phase II implementation, the department abruptly terminated all expansion efforts in May 2001. Ostensibly, the department could pursue managed care options for the ABD population under provisions of the federal Balanced Budget Act of 1997 without having to obtain Section 1115 waiver approval. However, as of this report, we are unaware of any departmental attempts to pursue this alternative. As a result, the department still has not demonstrated the efficacy of a managed care program for its aged, blind, and disabled clients, who remain the most expensive health care cost clients for the State both on a per capita and absolute cost basis.

HCFA also questioned QUEST's expansion

Echoing our 1996 report, the federal Department of Health and Human Services' Health Care Financing Administration (HCFA) also expressed concern that problems associated with Phase I should be resolved before Phase II was implemented. Specifically, HCFA noted that the State did not have an acceptable management information system in place. Consequently, most of the data and information needed for HCFA to assess whether the State could adequately manage the QUEST project could not be provided. In addition, the department had failed to provide required quarterly reports, had not yet performed federally required analyses of encounter data, and had not provided copies of any internal and/or external audits monitoring the performance of health plans.

Administration did not support conversion to managed care

Departmental personnel also indicated that a lack of support for QUEST Phase II from administration—both internal and external to the department—additionally hindered its proposed implementation. Although the department officially pursued Phase II plans for seven years, a Med-QUEST Division administrator noted that the implementation of Phase II would have been cost prohibitive because the ABD population is the most costly group to serve on a fee-for-service basis, and the additional administrative costs involved in converting this group to a managed care system were viewed as a major impediment.

Under the managed care program (Phase II), administrative costs for the aged, blind, and disabled group are estimated to be about \$90 to \$105 per participant per month; in contrast, Phase I enrollees' administrative costs are around \$22 to \$26 per participant per month. For this reason, according to a division administrator, implementation of Phase II has been, and continues to be, cost prohibitive.

Furthermore, a former director of the Department of Human Services noted that the department continued to pursue Phase II implementation despite eventual opposition by the Med-QUEST Division's own administrator. The former director, noting that despite the fact that the aged, blind, and disabled population on a per capita basis was the most expensive of the Medicaid-funded programs, commented that the executive branch lacked commitment in pursuing Phase II. As shown in Exhibit 2.2, the average per capita expenditure for the aged, blind, and disabled was \$9,443, over five times more than the \$1,620 per capita expenditure for adults and children.

**Exhibit 2.2
Medicaid Spending Per Enrollee for Federal Fiscal
Year 1997-98**

	Adults and Children	Aged, Blind, and Disabled
Expenditures	\$236,621,045	\$357,744,273
Number of Enrollees	146,054	37,883
Expenditures per capita	\$1,620	\$9,443

Source: Kaiser Foundation on Medicaid and the Uninsured

**Aged, blind, and disabled clients and service providers
opposed conversion**

Lack of executive commitment to implement Phase II may also have reflected the opposition by both clients and service providers of the aged, blind, and disabled group to convert to a managed care system. When Phase I of QUEST was initially implemented, participants understood that they would be assigned to—rather than be able to choose—programs and physicians. Although this practice was changed, the aged, blind, and disabled population continued to believe that under the managed care program, they would not be able to maintain existing long-standing relationships with practitioners of their choice.

There were also concerns that managed care would limit the level and type of care provided and reduce the quality and type of care participants would receive. Furthermore, both physicians and program administrators noted that determining a suitable capitation rate was difficult for the aged, blind, and disabled group. A division officer observed that an estimated capitation rate between \$600 to \$700 was required to cover provider costs, but given the level of medical care needed for this population, determining an amount that would satisfy both the objectives of the department in containing costs and the needs of providers was difficult.

Phase II implementation was abruptly terminated

In response to HCFA concerns about deficiencies with QUEST’s management information system, the department delayed the decision to pursue Phase II implementation. Instead, the department sought an extension to the existing demonstration project phase, along with plans to implement the required management information system. Together, the extension and delay would permit the QUEST Demonstration Project to continue and the required management information system to become operational before expanding the project’s scope.

On February 15, 2001, the department notified its Phase II Task Force Members of the intent to resume Phase II implementation. The department informed task force members that, in addition to HAPA (Hawaii Arizona PMMIS Alliance), other management deficiencies had been addressed. The department hoped to get HCFA approval to proceed with Phase II by Summer 2001.

However, on May 18, 2001, the department abruptly announced to HCFA that it was terminating all efforts related to Phase II implementation. In its notification, the department said it was dropping the Phase II proposal and would pursue the ABD managed care system under provisions of the 1997 Balanced Budget Act. The provisions allow for enrolling participants like the aged, blind, and disabled into managed health care programs without obtaining a waiver approval. However, a division officer indicated to us that a firm decision to pursue managed care for the aged, blind, and disabled under the Balanced Budget Act had still not been made as of December 2002.

Federal budget neutrality is not a concern

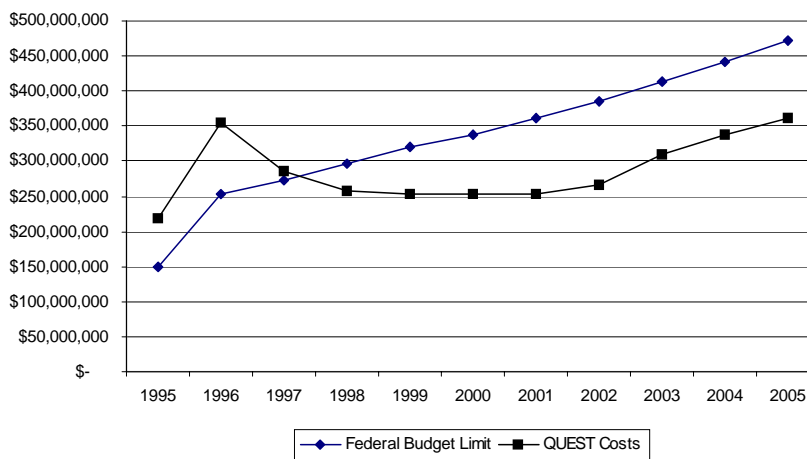
Failure to meet federal budget neutrality requirements, a concern identified in the 1996 audit, is currently not a problem. The Med-QUEST Division reports that the QUEST Demonstration Project is well within federal budget limit requirements. Under Section 1115 waiver provisions, the federal share of managed care Medicaid funding cannot exceed what the federal government would have expended on Medicaid had the project not been implemented.

Budget neutrality is calculated individually for each state. For Hawaii, the calculation is based on Medicaid expenditures in the year the QUEST Demonstration Project was approved (1993), adjusted annually by a cost of living/inflation factor. The federal government determines budget neutrality by a cumulative total over a set period. While expenses in any given year may exceed federal budget limit guidelines, the cumulative total over a period of years determines whether budget neutrality has been achieved. Hawaii's budget neutrality period has been adjusted to cover the demonstration project's approved extensions, i.e., from 1994 to 2005.

The department's budget neutrality information shows that since 1998, QUEST Demonstration Project costs have been less than the federal budget limits. Similarly, between 2000 and 2001, the cumulative difference between project costs and federal limits reached zero and is anticipated to remain lower than the expenditures limits that determine federal budget neutrality. This trend is expected to continue despite anticipated increases in project expenditures, thus providing a cushion to meet federal budget neutrality requirements.

However, this degree of cushion essentially reflects the project’s lack of expansion. As shown in Exhibit 2.3, the federal budget limit is projected to remain well above projected QUEST expenditures. Although QUEST’s goals and objectives reflected an expanding managed care health system, projected expenditures that are comfortably within federal budget limit guidelines instead show no evidence that the project will expand to cover more participants.

**Exhibit 2.3
Federal Budget Limits vs. QUEST Costs, 1995-2005
(actual and projected)**



Source: Med-QUEST Division, Department of Human Services

In addition, QUEST remains a demonstration project and regardless of its compliance with federal budget limitation requirements, must continue to seek federal approval to renew its demonstration authority every few years. The National Conference of State Legislatures' 2002-2003 policy statements on health supports a reduction of the Medicaid program's dependence on waivers, and suggests that when waiver programs are determined to be successful, statutory authority for the program be pursued, thereby ending the requirement for demonstration authority renewal. In view of substantial state resources committed to QUEST, the department should consider this action if it determines that the QUEST project should continue.

Cost savings remain questionable

The QUEST Demonstration Project has been promoted as a project that will save money for the State. Our 1996 audit reported that the Department of Human Services claimed in its first five years QUEST was projected to “save” the State \$400 million. However, this claim confuses the actual intent of the QUEST project, which is not to save the

State money directly, but to expand health coverage to include participants not eligible under the traditional fee-for-service system. A managed care system, such as QUEST, is intended to result in more effective and efficient use of funds rather than the expenditure of fewer actual dollars. QUEST's program of preventive care and capitated payments has made more effective use of existing state and additional federal funds, thereby resulting in a savings to the State and permitting more persons to receive health care.

Thus, managed care has resulted in "cost savings" by reducing the cost to provide equal or better health care services to individuals through a managed care system. However, cost savings is not the same as saving the State money. In fact, an expansion of the QUEST Demonstration Project as originally projected would have resulted in an increase in state expenditures. In order for the QUEST Demonstration Project to expand services as planned, more state funds—in addition to those realized through more effective use of existing funds—would be required. Failure to increase total available funds has contributed to QUEST's inability to expand, which is also reflected in the gap between its expenditures and the federal budget limit.

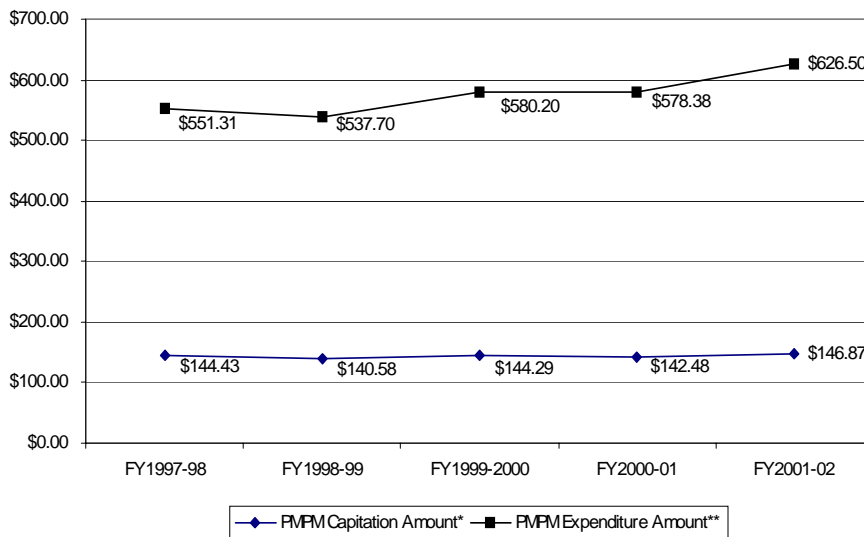
According to the Department of Human Services' Annual Fiscal Report for Fiscal Year 2001, QUEST health plans saved \$3,043,623 as a result of its Third Party Liability program (TPL), and the Medicaid program "cost-avoided" \$122,131,298. TPL ensures that clients who have other insurance coverage exhaust those benefits before utilizing Medicaid fee-for-service or QUEST benefits. However, it is not clear how much of the savings from TPL can be attributed to QUEST, since fee-for-service reimbursements are not part of QUEST; and QUEST participants who have other health insurance may not have been covered by Medicaid before the Section 1115 waiver project was implemented.

Additionally, the department's annual report states that of the \$122,131,298 cost-avoided by the Medicaid program, \$98,481,825 (81 percent) was attributable to the Medicare program. Since Medicare generally does not participate in managed care programs such as QUEST, most of this reported cost-avoidance cannot be attributed to QUEST.

Continued cost containment is questionable

The QUEST Demonstration Project kept enrollment and expenditures relatively stable during the latter part of the 1990s, and the division reports that the total average monthly capitation payment has increased by only about two percent between FY1997-98 and FY2001-02. However, during the same period, average monthly fee-for-service expenditures increased by 13.6 percent. Exhibit 2.4 illustrates these differences.

Exhibit 2.4
QUEST Capitation Versus Fee-For-Service
Expenditures Per Member Per Month
(PMPM), FY1997-98 through FY2001-02



* Includes all medical, dental, reinsurance, and transplant costs. All costs are recorded by dates of service.

** Includes all medical, dental, reinsurance, and transplant costs, but excludes costs for nursing facilities.

All costs are recorded by dates of service.

Source: Med-QUEST Division, Department of Human Services

The project’s ability to continue controlling costs is questionable. As previously noted, unbudgeted program expenditures were incurred when the enrollment cap was temporarily lifted, which resulted in a request for additional funding during Fiscal Biennium 2003-05.

Furthermore, the National Conference of State Legislatures reports that the majority of states will face a health care budget shortfall for 2003. The Kaiser Commission on Medicaid and the Uninsured found from two surveys conducted in 2002 that states had increased their projected Medicaid spending from 4.8 to 9.0 percent for FY2002-03, with Hawaii reporting a 22.5 percent increase in the cost of prescription drugs during the last fiscal year. Concerns about an inability to control rising Medicaid costs were also voiced by a former Department of Human Services director, who contended that unless the federal government intervenes, state Medicaid programs such as QUEST will be forced to

cut back on services and clients in order to keep costs under control. The former director felt that spiraling costs were beyond the control of individual state Medicaid offices.

Lack of dental provider participation is problematic

Failure to maintain dental services under managed care is indicative of the challenges that face such a system. When the QUEST Demonstration Project was initiated in 1994, full dental services were available under three dental plans. To control costs, dental services were subsequently reduced to emergency care only for adults (children continued to receive full services). In 2001, the department announced that those same dental services would be retained, but would revert to the fee-for-service program rather than be continued under the QUEST Demonstration Project.

A Med-QUEST Division officer noted that because of low reimbursement rates for dental services, QUEST has been unable to retain either sufficient individual dentists or dental plans to participate in the project and still meet Section 1115 waiver requirements. A former departmental director also confirmed this difficulty, adding that dentists are much more independent than other health care providers; and in any event, getting cooperation in a managed care environment is always problematic.

Under a managed care environment, practitioners are paid a capitated rate to provide agreed upon services. If a capitation rate is perceived as insufficient for a practitioner to provide the level and degree of services specified, he or she can decide not to participate. This scenario is not necessarily unique to dentists; it represents the type of risk the State faces when implementing a managed care program. Failure to provide a capitation rate satisfactory to practitioners can result in a lack of provider participation. This in turn can reduce the State's ability to negotiate favorable capitation rates as a means to keep costs under control.

The intent of the QUEST Demonstration Project was to demonstrate that a managed care system was a more effective method of utilizing state funds for health care. Although QUEST has maintained a relatively stable expenditure pattern, it has done so primarily by limiting enrollment and the services it provides, and has not demonstrated that it is able to expand services.

Management Control and Staffing Problems Still Hamper QUEST's Operations

Effective management and processing of eligibility determination and re-verification are essential to efficient operations of the QUEST Demonstration Project. Previous audits issued by our office consistently highlighted operational weaknesses in eligibility application, re-verification, and payment processing. Our current audit found that procedural changes have reduced backlogs, but increased the chance that ineligible applicants receive benefits. We found the eligibility review process has improved but still demonstrates weaknesses that hinder effective operations; and we concluded that some of the continuing management control weaknesses appear to be associated with ongoing staffing concerns.

To assess progress made on management control problems identified in previous audits, we selected a judgmental sample of approximately 600 official cases from the division's active case file listings. The division provided us with a sample "dummy" case file identifying the types of documentation that should be kept in each case file. Case files were reviewed at the Oahu, Kauai, Maui, East and West Hawaii, and Molokai Med-QUEST Eligibility Branch offices. Files for Lanai, maintained at the Molokai office, were reviewed along with the Molokai files.

Some files were selected at random; other files were selected on the basis of annual eligibility review dates. Although the total sample was not random, based on the number of files selected and subsequent discussion with branch eligibility personnel, our findings are fairly typical. We interviewed branch eligibility personnel, other division and departmental personnel, and reviewed documentation pertaining to case files.

In response to specific questions on case files, eligibility office administrators accessed the online "working" case files maintained on the HAWI (Hawaii Automated Welfare Information) system, the State's certified Family Assistance Management Information System that maintains eligibility information for Temporary Assistance to Needy Families (TANF), food stamps, and Medicaid. The HAWI system, although used by the Med-QUEST Division for eligibility determination, is operated and maintained by the department's Benefit, Employment and Support Services Division (BESSD).

Self-declaration and presumptive eligibility practices reduce application backlog

Procedural changes implemented since our last audit have significantly reduced QUEST's backlog of outstanding applications, but have increased the risk that ineligible persons may receive benefits. In 2001, (Report No. 01-10) we reported a backlog of approximately 1,100 QUEST applications had been outstanding for over 45 days; further, that this was a continuing pattern identified in previous audits. The

department subsequently reported that the backlog had been eliminated. However, the elimination was due to procedural changes: the division adopted policies of client self-declaration and presumptive eligibility. While these changes have significantly diminished the backlog of outstanding applications, they place a greater burden upon subsequent eligibility reviews to verify that clients remain qualified for services.

Presumptive eligibility has reduced backlog

Presumptive eligibility requires that applicants receive services if a decision on eligibility has not been made within a specific timeframe. Hawaii Administrative Rules specify that a presumption of medical eligibility shall be made effective from either the forty-sixth or sixty-first day, depending on eligibility category, until a determination is rendered.

We found that backlogs of applications existed because Med-QUEST eligibility offices failed to apply the presumptive eligibility requirement when applications were delayed beyond the required processing time. Eligibility branch personnel indicated an awareness of the 45-day limit on the wait period but admitted that in the past, incomplete applications had been left pending beyond that period. Determination of eligibility must be made 45 days from the date of application for all applicants except for applications made on the basis of disability, for which it is 60 days.

Neighbor island staff generally do not resort to use of presumptive eligibility because they are more up to date with their eligibility determinations and are able to process applications within the 45-day period. However, the Oahu-based eligibility branch administrator reported that Oahu caseworkers routinely presume eligibility if they are unable to process an application by day 45. By routinely enacting the presumptive eligibility requirement, the division has virtually eliminated the backlog of applications. However, the former departmental director acknowledged that while the backlog has been reduced, it has not changed the existing problems with processing applications.

Self-declaration also eases verification process

The application process has also been expedited by the practice of self-declaration. Application processing requirements specified in Chapter 1711, Title 17 of the Hawaii Administrative Rules states that eligibility for the QUEST program is to be determined based on information provided on the application form. The self-declaration policy in force on all islands and several eligibility office personnel noted that this has eased the verification process.

Generally, according to the eligibility branch administrator on Oahu, eligibility is determined within 45 days. In contrast, eligibility determination on the neighbor islands takes from one to three weeks. Self-declared information is supposed to be verified by the department whenever possible; however, such verification is often not performed until the annual eligibility review. Although self-declaration information is accepted, eligibility branch personnel admit they cannot be sure that what clients state on the form is accurate.

Some Med-QUEST eligibility branch offices report having largely eliminated client interviews, relying instead upon client self-declarations for income and asset information. Subsequent eligibility reviews are supposed to be used to re-visit and verify the accuracy of previously self-declared information; however, eligibility branch staff note that they often lack the time and resources to complete such verifications. Furthermore, they admit that while the process is faster, it is less reliable. One eligibility officer even commented that while “self-declarations are a lot faster,” the officer doubted whether all the clients who have cell phones and property were telling the truth about their assets on their application forms.

As a result of these procedural changes, many of the previously reported eligibility application processing problems no longer appear to be an issue because backlogs have been eliminated. However, this has been accomplished at the expense of the accuracy of verification.

Official case file records lack proper and timely documentation

Our review of official case files showed that despite improvements in management control, proper and timely documentation continues to be lacking in case files. We reviewed official case file records at the Oahu, Kauai, Maui, Molokai and East and West Hawaii Med-QUEST eligibility offices as part of our follow-up of previously identified management control problems. Case files were reviewed for completeness and timeliness of required documentation, certifications, and evidence of supervisory review. We found that many of the case files lacked such evidence. In addition, the Oahu office was unable to locate five of 187 files selected for review, and 10 files appeared to have been created after our list of requested files was transmitted. They contained only a computer printout and no official documents.

HAWI records are more reliable than official case files

We found that eligibility offices rely upon the HAWI computer records for day-to-day operations because case file documentation was sometimes incomplete. In contrast, almost all of the cases reviewed had current HAWI records that included current eligibility dates, disposition, annual review determinations, and eligibility code for the type of service

provided. The exception to this was at the Molokai office, where the eligibility worker was unable to obtain adequate supplies of computer paper. As a result, there were inconsistencies between HAWI and other printed documents in the case files.

It became evident during our audit fieldwork that eligibility workers primarily rely upon working files or HAWI computer records rather than the official case file as their normal reference. In most instances, questions arising from our case file review were answered by checking the HAWI system. We were told that eligibility workers tend to place a higher priority on updating the HAWI system while delaying updates to official case files. For example, the working HAWI computer file is usually current, whereas files for cases that are unquestionably eligible for services or otherwise considered routine may be updated only as times allows between other tasks. The Oahu office was an exception, where some inquiries on HAWI generally confirmed that both the file and eligibility review were delinquent.

Case files are incomplete and inconsistent

While the majority of the 600 case files we reviewed across the state were current, we found numerous examples of incomplete, inaccurate, or inconsistent documentation. Standard, required documents—such as official copies of the application and eligibility determination/disposition forms—were often incomplete. Some applications for medical assistance (form DHS 1100) were neither signed nor dated by the caseworker. In a few cases, there was no such current form in the file. The application form requires the Med-QUEST worker to verify that the applicant has been advised of the rights and responsibilities of both the applicant and department; however, in many instances this form was not signed.

For instance, caseworkers in Kona executed the form only when they met with applicants in person. Geographically, the Kona office is responsible for the majority of the island of Hawaii. As a result, applications there are often handled by telephone, and certifications consequently remain unsigned. Another office's administrator believed the caseworker signature for certification was optional.

In addition, the department has recently revised the application form, and both forms are currently in use. Part of the new DHS 1100 application form includes a detachable page for the applicant listing the rights and responsibilities of both the applicant and department. While this page had been removed in the majority of files we reviewed, in most cases the eligibility workers had not signed the form to certify that the applicant had been notified. We note that, next to the signature block, there is no indication why eligibility workers need to sign the new form, and at least one office administrator was similarly unclear on this point.

Another required form, the DHS 1100A, constitutes the official disposition and record of decision regarding an application for benefits. We found examples of such forms that contained no disposition, were not signed, or were missing. This form is also supposed to indicate that a caseworker has verified an applicant's eligibility. The Oahu administrator noted that, at least at the Oahu office, retaining copies of supporting documentation is discouraged; therefore, written disposition on this form may be the only evidence that verification has been carried out. Failure to complete the form means there is no other documentation that the verification process has been performed.

Finally, in several cases HAWI computer printouts were substituted for one or both of the required forms. While HAWI printouts may contain current file information and useful summary information, they cannot be considered a substitute for official documents.

Med-QUEST Division still lacks a uniform standard operating procedures manual

The Med-QUEST Division does not consistently follow standardized procedures in processing QUEST applications because it still lacks a current standard operating procedures manual. Procedures are supposed to be common to all offices; however, the standard operating procedures manual is outdated. In 1999, it was reported that eligibility workers from Med-QUEST Division and BESSD had drafted a standard operating procedures manual to be used by both divisions. However, the offices are using a May 15, 1999 version that is identical to the original 1994 version.

The lack of a procedures manual results in gaps in some processes. These gaps can create confusion and lack of uniform documentation in cases such as transitions from BESSD with full financial benefits to QUEST medical-only benefits; foster care eligibility cases; and Transitional Medical Assistance eligibility cases. In all three scenarios, cases are transferred or require input from another agency (BESSD or Child Protective Services, in the case of foster care). However, we found that documentation in the Med-QUEST files is frequently incomplete.

Backlog of eligibility reviews appears proportional to caseload

We found that the extent of backlog within the Med-QUEST Division appears directly related to worker caseload. Oahu, with the highest caseload per worker, is the most backlogged, while neighbor island offices, with significantly smaller caseloads, are more current with their eligibility verifications.

The Med-QUEST Division continues to experience problems due to its failure to adequately assess QUEST's staffing requirements. Our 1996 audit, which found that QUEST's hasty implementation resulted in inadequate staff to manage the project, recommended that the Med-QUEST Division assess the work required and consider alternate staffing options to ensure that qualified people are engaged to do the work. We found that while a number of steps have been taken, such as conversion of temporary positions to permanent and contracting out to meet some of the management information and claims processing needs, the division still appears to be hampered by its failure to assess staffing requirements adequately.

Oahu has the weakest eligibility verification process

The Med-QUEST Division's Oahu eligibility branch office had the most problems in our case file review. We found 88 of 187 case files we reviewed, approximately 47 percent lacked evidence of a completed annual eligibility review. Our review was intended to determine the extent to which QUEST eligibility offices were still experiencing problems in ensuring:

- Consistency in the administration of QUEST's eligibility process,
- Completion of annual eligibility re-verification,
- Timely disenrollment of ineligible clients, and
- Compliance with QUEST program case file requirements for documentation, certification and evidence of supervisory review.

In addition to lacking completed eligibility reviews, some Oahu cases were not given a disposition within the required 45 days. Three cases were overdue at more than 100 days from application to disposition, and one was at 218 days at the time of our review. There was no evidence that presumptive eligibility was given on the forty-sixth day, and no actual eligibility date was provided. The Oahu office was the only office that was unable to provide case files for all sample cases selected for review. The administrator also acknowledged that eligibility reviews were frequently late, resulting in a backlog of uncompleted reviews.

The administrator contends that part of the problem is due to insufficient staffing. Based on December 2002 caseloads, the Oahu Eligibility Branch Office reports that Oahu averages approximately 1,050 cases per worker, while neighbor island offices report between 620 to 770 cases per worker. In practice, with the current freeze on filling vacancies, the Oahu caseload per worker rises to over 1,120 per worker. In contrast,

average caseload per worker for the department's Benefit, Employment and Support Services Division (BESSD) on Oahu is 180 cases.

The Oahu administrator contends that although many Med-QUEST positions were converted from temporary to permanent, workers still transfer to BESSD when openings become available because of the workload differences.

More than one Med-QUEST administrator said the ostensible difference between caseloads is attributed to the requirement that the BESSD workers handle financial assistance and food stamps, in addition to clients' medical assistance. However, Med-QUEST officials state that, in fact, the Med-QUEST staff's familiarity with medical services requirements means that they handle the majority of BESSD cases' medical-related services in addition to their own.

Furthermore, a "case" often constitutes a family, with family members separately evaluated to determine their qualifications and separately evaluated for different types of Medicaid programs. For example, an adult may be subject to income qualifications that are not applied to children.

Neighbor islands are more current

In contrast to Oahu, we found that neighbor island case files at Med-QUEST eligibility offices in East Hawaii, West Hawaii, Kauai, and Molokai were generally up to date, with few anomalies. Annual eligibility reviews were completed in a timely manner, and few of the cases reviewed exceeded the 45-day disposition requirement. Generally, cases were closed when the client failed to provide adequate information for the eligibility review or to complete the review process on time. Our file review showed that clients who no longer qualified for participation in a QUEST program were denied services. When questions about documentation in the case files arose, a review of the HAWI system online generally showed that the case was current; issues identified in the review were clerical in nature and not substantive.

The exception for the neighbor islands was the Maui Med-QUEST Division office, where over 20 percent of case files reviewed did not have a current annual eligibility review. The Maui eligibility office supervisor noted that caseworker assignments vary according to experience and classification level of the caseworker. Maui's five seasoned caseworkers carry a caseload of between 575 and 625 cases each, while less experienced caseworkers handle fewer cases and/or less complex cases. The supervisor also reported that the Maui office was short of personnel.

Similar to Oahu, some neighbor island offices were experiencing problems due to the recently imposed hiring freeze. Turnover did not appear to be a major factor on the neighbor islands, since alternative jobs are limited. Moreover, higher-level QUEST eligibility workers would normally have to take a reduction in classification if they transferred to BESSD, because they are not trained in financial and food stamp areas.

However, it appears that, particularly for Oahu, a realistic assessment of staffing requirements has not been completed. While the Oahu office appears to prioritize the certification of eligible clients, failure to review cases in a timely manner can result in continuation of services for those no longer eligible. Given the limited slots available due to the enrollment cap, failure to disenroll clients who no longer qualify further delays services for those who would otherwise be eligible.

Staffing concerns in previous audit are not adequately addressed

Our 1996 audit found that QUEST's hasty implementation resulted in inadequate staff to manage the project; we recommended that the Med-QUEST Division assess the work required and consider alternate staffing options to ensure that qualified people were engaged to do the work. Our current audit found that while a number of steps have been taken, such as conversion of temporary positions to permanent and contracting out to meet some of the management information and claims processing needs, the division still appears to be hampered by its failure to assess and resource its staffing requirements adequately.

Despite our 1996 audit stating that making temporary positions permanent was not a complete solution to Med-QUEST's staffing problems, many temporary positions have now been converted to permanent. However, the division continues to experience problems with inadequate staffing but has not developed a plan to address these issues. Considering the likelihood that a managed care health system will continue to be the State's preference for delivery of health care services, the department still needs to develop a realistic assessment of QUEST's operational requirements, including staffing. Such an assessment would provide the Legislature with information on the requirements necessary to support a managed care system.

QUEST is technically a demonstration project and therefore faces periodic renewal under the Section 1115 waiver process. However, Center for Medicare and Medicaid Services officials note that while continuation of the demonstration project program is up to Congress, only one project's waiver authority has been withdrawn for failure to meet project requirements. In addition, managed care is still viewed as a viable means for government to provide health care for the financially challenged. Supporting this view, the Department of Human Services' plans for QUEST continue as though the project were permanent.

In light of this and the considerable resources invested in QUEST including conversion of a number of temporary positions to permanent, it would appear reasonable that the department pursue making the program permanent. Whether or not this is pursued, a realistic assessment of present and future needs based on program goals would be prudent. Such an assessment would provide the Legislature with information to evaluate the requirements necessary to support a managed care health system.

Physical requirements also need addressing

The purpose of an assessment is to help QUEST identify alternatives to improve its operations. During our site visits, we observed an overflow of case files stored unsecured throughout each of the offices. The situation was most pronounced on Oahu, where the administrator commented that Med-QUEST is required to retain closed case files for four years. With no storage facilities, staff are forced to store files in any space throughout the office. On Oahu, files are kept on open shelves, while neighbor island offices use a combination of file cabinets and open shelving. As the State's primary managed health care system, QUEST must assess its conditions, including case file storage in order to improve the efficiency of its operations.

A Management Information System Has Finally Been Implemented

In December 2000, six years after the QUEST Demonstration Project was established, HAPA (the Hawaii Arizona Prepaid Medicaid Management Information System—PMMIS—Alliance) was implemented. An adaptation of Arizona's PMMIS system designed to meet Hawaii's management information systems needs, HAPA is the first state-to-state partnership to jointly share the costs and development of a management information system. This shared technology approach resulted in an operational system that the previous independent effort was unable to produce. While it may be too soon to thoroughly assess the success of the shared technology, we believe an evaluation of HAPA and its shared technology approach is warranted to assess the applicability of this approach for other applications.

A management information system was required since inception

A condition of the Section 1115 Medicaid waiver approval was that states have an information system capable of processing program data necessary to administer an efficient and effective Medicaid managed care program. When the Section 1115 waiver was approved for the creation of the QUEST Demonstration Project, Med-QUEST Division's information system was designed to handle only existing fee-for-service clients. To address Section 1115's managed care information system requirements, the department carried out temporary fixes to existing information systems while working on a plan to design, develop,

implement and maintain a new system. In December 1994, four months after QUEST was implemented, a contract for the development of an information system was awarded to Unisys.

Original efforts to develop a system failed

After experiencing a series of problems and setbacks, the Department of Human Services formally agreed to terminate its contract with Unisys in 1997. As reported in our 1996 audit, Unisys acknowledged its difficulties with the project and the complexities of developing an entirely new system to meet the QUEST management information system needs. Our audit also noted that Unisys had gone as far as replacing the entire project team with personnel completely new to the project; but even this measure did not help Unisys produce the requisite management information system.

Our 1996 audit also noted problems with Med-QUEST Division's commitment to develop a management information system. The division had not provided the necessary staff to support the system's design and implementation, which affected the contractor's ability to complete the system's installation.

Unisys failed to fulfill its contract

More than three years after QUEST's inception, the management information system necessary to manage the demonstration project and provide the requisite data required by HCFA was still non-existent.

Following termination of the Unisys contract in October 1997 for failure to deliver the required system, several new alternatives were considered. These included:

- Issuing a request for proposals (RFP) to design, develop and implement an information system customized for Hawaii's needs;
- Purchasing commercial "off-the-shelf" software and modifying it to meet the program needs;
- Transferring Arizona's information system and maintaining the system in Hawaii; and
- Contracting/partnering with Arizona for the information systems support, with the system located in Arizona.

The department elected to pursue a partnership with Arizona, which already possessed an approved, functional Prepaid Medical Management Information System (PMMIS). In addition, Arizona and Hawaii are in

the same federal region; Hawaii's QUEST Project had been patterned after Arizona's program; and HCFA looked favorably upon the idea of sharing resources. With the exception of HCFA's formal endorsement, we note that all of these conditions existed when the department first attempted to satisfy management information system requirements in 1994, but were apparently not identified as viable alternatives.

Stopgap measures were utilized to meet QUEST's PMMIS needs

Prior to implementation of the HAPA system, the department developed a number of interim systems in an attempt to keep the QUEST project operational. Besides continued reliance upon the Benefit, Employment and Support Services Division's (BESSD) HAWI information system for eligibility determination, three additional interim systems were applied to satisfy reporting and operational requirements. These included: a Premium Share system to track premium share data; a Payment to Plans program designed to track monthly capitation data; and an Encounters program developed to collect encounter data. Although these interim measures enabled the division to provide required data information, they remained disjointed and required significant effort to maintain.

Arizona's system was adapted to meet QUEST's PMMIS needs

In 1999, the department contracted with the Arizona Health Care Cost Containment Systems Administration (AHCCCS) to adapt its existing system to accommodate Hawaii's requirements. Since AHCCCS was already meeting similar reporting requirements for its own system, Hawaii's requirements were considered straightforward. This arrangement was advantageous for Hawaii because it provided for timely implementation of a proven system and did not require significant additional staff, since Arizona was responsible for system maintenance. Arizona benefited from the arrangement because Hawaii helped to offset system costs.

In December 2000, after completion of a November 2000 readiness review to sort out any last minute concerns, the HAPA system was implemented. In May 2001, it was reported that both the Hawaii and Arizona systems were fully synchronized so that all future upgrades would be coordinated as needed between the systems.

Arizona continues to maintain the HAPA system, which resides on Arizona's computer system. The original contract for HAPA was modified to incorporate Hawaii's fee-for-service Medicaid Program in addition to QUEST. In October 2002, conversion of the fee-for-service program previously provided by HMSA was accomplished, and HAPA assumed operations for this service. To maintain the system, Arizona

reassigned HAPA's special development team to application support teams to address the ongoing needs of both Arizona and Hawaii's systems. While Med-QUEST Division personnel have not noted major problems with HAPA, concern has been expressed that Hawaii's system requests may not receive the same priority as Arizona's.

ACS, Inc. was retained to process claims

As part of the conversion, Affiliated Computer Services, now known as ACS, Inc. was retained to process the Medicaid fee-for-service claims, assuming the function previously managed by the Hawaii Medical Services Association (HMSA). ACS, Inc. was also selected to manage the Prescription Benefit Management Program, a program designed to support the online drug utilization review, claims processing, prior authorization, information management, provider help desks, clinical support, rebate and formulary management of the State's Medicaid Programs.

Shared technology needs evaluation

HAPA is the first example of a state-to-state partnership to develop a management information system. Hawaii benefited from Arizona's proven and certified system and the ease by which the Arizona system could adapt to Hawaii's needs. In addition, the HAPA system would be serviced and maintained by another state's already well-established information systems branch.

The Centers for Medicare and Medicaid Services (CMS) has endorsed the shared technology concept as a potential way to share and effectively use existing resources. This is not the first example of system adaptation: the Department of Human Services' HAWI system, which processes eligibility determinations of potential clients, was also adapted from an existing Arizona system.

Our office has frequently reported state agencies' efforts to implement new information systems have been difficult or problematic. This was certainly the case with the Department of Human Services' original attempt to develop a QUEST information system. Although adaptation of another state's system—as Hawaii was able to do with Arizona's PMMIS—may not be feasible in all cases, shared technology is a concept other state agencies should consider in future information systems development projects. While there are cost and operational advantages to sharing technologies, a more formal evaluation should be performed to determine the efficacy of sharing technologies for other information system projects. The evaluation should be performed after the department accepts the HAPA system as complete and fully functional.

Conclusion

Nearly ten years since the proposal was first approved, the QUEST Demonstration Project still suffers after-effects from inadequate planning and hasty implementation. As a result, the State's objectives to implement a health care delivery reform effort have progressed no further than its initial efforts, as the project struggles to establish a management control system to effectively support a managed care system.

Although project expenditures have been controlled and are currently within federal budget neutrality requirements, changes in Medicaid expenditures, provider participation, and the recent temporary lifting of the enrollment cap place the program in a budget shortfall position and raise concerns about its ability to continue to keep costs under control. Operational changes have improved the performance of the QUEST Demonstration Project; and the required management information system has finally been implemented. However, the department has yet to make a concerted effort to assess staffing and other operational requirements to effectively support the project.

Managed care systems such as QUEST are advocated as a means of providing cost control, increased federal cost sharing, and expansion of client coverage. However, these advantages are tempered by the added risk states assume when expanding services. While QUEST has demonstrated the potential feasibility of the managed care approach, the project is overshadowed by the department's failure to realistically assess the logistical and financial support necessary to implement a systemic health care reform effort.

Recommendations

1. The Department of Human Services should evaluate QUEST's efficacy and appraise the time and resources (human, financial, and physical) necessary to continue and/or expand the demonstration project. If the evaluation concludes that the managed care concept should be continued, statutory authority should be sought to make the project permanent and end the renewal requirement mandated under the demonstration waiver process.
2. The Department of Human Services should ensure that a standard operating procedures manual is adopted and followed by the Med-QUEST Division. The manual should include standard procedures for processing eligibility applications as well as handling of cases that are transferred from other departmental divisions.

3. The Department of Human Services should evaluate HAPA to assess the efficacy of shared technology to fulfill information system requirements. The department should also ensure that such alternatives are identified and evaluated as part of the information system decision-making process.

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Appendix A
Department of Human Services' Med-QUEST Division
Programs

PROGRAM	DESCRIPTION
Hawaii QUEST Managed Care Demonstration Project (QUEST)	A Section 1115 Waiver demonstration project that places AFDC, GA, and parents and children below minimum income standards under a managed care health program.
Medicaid Fee-for-Service (FFS)	Covers eligible residents who are aged 65 and older, blind, or disabled.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Provides additional Medicaid services for clients under 21 years of age. No co-payment is required. Services include: complete medical and dental examinations; hearing, vision and laboratory tests; immunizations and skin tests for tuberculosis; assistance with necessary scheduling and transportation upon request; and additional needed treatment for conditions detected during screening.
QUEST-Net	Offers limited benefits to clients who were previously enrolled in QUEST or FFS but have lost coverage due to increasing income, assets or other qualifying reasons. Services for children enrolled in QUEST-Net are the same as those offered in QUEST. Maternity benefits are not available in QUEST-Net, but clients can receive full maternity benefits under QUEST once eligibility is determined.
QUEST Spenddown	Provides medical and dental coverage to certain families with children who, because of their income, are not eligible for coverage under QUEST. It may also cover QUEST-Net clients who have medical needs not covered under QUEST-Net or whose benefits have been exhausted.
Transitional Medical Assistance (TMA)	Provides continued free medical coverage for up to 12 months after a client is determined no longer eligible for benefits under Section 1931 of the Social Security Act (provides free medical assistance to those meeting AFDC standards for assistance). Client must: 1) have been Section 1931 eligible but lost eligibility due to increased earnings or loss of earned income exemptions, and 2) have a child under the age of 19.
State Children's Health Insurance Program (S-CHIP)	Provides additional health coverage to children under 19 years of age from families that have incomes less than 200 percent of the federal

PROGRAM	DESCRIPTION
	poverty level (FPL). This program is authorized under Title XXI of the Social Security Act. The State's portion of the costs for this program is taken from the its share of the Tobacco Settlement Funds. Hawaii was one of the last two states to implement a program and therefore showed an 87 percent growth in the program's participation in its first year, from 3,854 in December 2000 to 7,190 in December 2001.
Immigrant Children's Program	Provides services similar to those of S-CHIP to immigrant children who do not qualify for S-CHIP. Funded entirely from state funds.
Breast and Cervical Cancer Program	Medicaid fee-for-service is available to individuals under the age of 65 with cancerous or pre-cancerous conditions of the breast or cervix in accordance with Public Law 106-354, provided they have been screened and diagnosed by a physician approved by the Hawaii Breast and Cervical Cancer Control Program of the Department of Health. A similar program fully funded by the State is available for individuals who are barred from participating in the Medicaid program (Act 278, SLH 2001).
9-11 Net Program	Implemented in December 2001 under the provisions of Act 6, Special Session 2001, provides a temporary health insurance program for workers and their family members who lost employer-sponsored medical coverage due to September 11, 2001 events. Eligible persons pay \$63 monthly per enrollee for a limited medical benefits package.
COBRA Premium Reimbursement Program (Consolidated Omnibus Budget Reconciliation Act of 1985)	Implemented in January 2002, also under provisions of Act 6, Special Session 2001, eligible persons are reimbursed up to three months of COBRA premiums for persons who lost employer-sponsored insurance due to September 11, 2001 events and who subsequently enrolled in COBRA extended coverage. COBRA permits an eligible person who lost employment to receive the same benefits previously provided by an employer-sponsored insurance program for a period of 18-36 months at the person's own expense.
Funeral Payments Program	A partial payments program for mortuary and burial expenses available for persons who had been eligible for medical or financial assistance from the State, or whose body remains unclaimed, i.e., having no known surviving relatives or friends, or any legally responsible relatives.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Human Services on May 5, 2003. A copy of the transmittal letter to the department is included as Attachment 1. A copy of the department's response is included as Attachment 2.

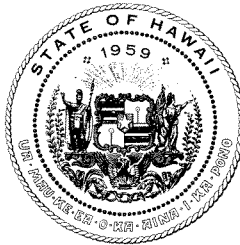
The Department of Human Services responded that it generally agreed with our recommendations. The department noted that QUEST cannot be made permanent through state statutory authority since it is a federal section 1115 program. We are aware of the federal requirements of QUEST and note that the recommendations were not meant to be limited to state-level actions. For example, the National Conference of State Legislatures supports federal statutory changes that would permit successful Medicaid waiver programs to be continued by statutory authority, thereby ending the requirement to seek renewal of the demonstration authority. Given the substantial state resources invested in QUEST, we believe it is reasonable to support such federal-level actions, if the State determines that QUEST should be considered permanent. Language to clarify this intent of the recommendation was added to the text.

The department agreed with our recommendation that the Med-QUEST Division needs to adopt a standard operating procedures manual, noting that the Benefit, Employment, and Support Services Division and the Med-QUEST Division have agreed to jointly develop the procedures manual. The department also noted that it had no objection to the recommendation that an assessment of HAPA be conducted to determine the efficacy of shared technology to fulfill information system requirements.

Finally, the department provided several comments intended to clarify the text in parts of the report. We made minor adjustments in the text to reflect these comments.

ATTACHMENT 1

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

May 5, 2003

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, *Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project*. We ask that you telephone us by Wednesday, May 7, 2003, 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 Tuesday, May 13, 2003.

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

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

Med-QUEST Division
Administration
P. O. Box 700190
Kapolei, Hawaii 96709-0190

May 12, 2003

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

RECEIVED
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OFF. OF THE AUDITOR
STATE OF HAWAII

Dear Ms. Higa:

Thank you for the opportunity to comment on your recommendations in your draft report, *Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project*. We have also commented on other parts of the report.

The first recommendation is that the Department evaluates the QUEST program and appraises the State Legislature of the time and resources necessary to continue and/or expand the demonstration project. We agree with your recommendation and intend to appraise the Legislature during the net session. Also, you recommend that if our evaluation concludes that the managed care concept should be continued, we should seek State statutory authority to make the project permanent and end the renewal requirement mandated under the demonstration waiver process. The Department is continually evaluating the QUEST program, and today, we would conclude that the managed care concept should be continued. However, contrary to your recommendation, the State is unable seek State statutory authority to make QUEST permanent. Statutory Medicaid provisions are reflected in the Medicaid State Plan. Programs, such as QUEST, require section 1115 waivers to deviate from the Title XIX and State Plan requirements in order to cover populations not normally eligible under Medicaid, restrict some choices usually available to recipients, and limit Medicaid coverage provisions of statewideness and comparability. Federal statutory amendments to Medicaid to accommodate Hawaii and the QUEST Program must be passed by Congress, and State statutes do not have the authority to override Federal statutory requirements. In short, the renewal of the QUEST demonstration project will be required unless there is a major overhaul of the Medicaid Program by Congress and such a change is highly unlikely.

The second recommendation is that the Med-QUEST Division adopts a standard operating procedures manual. We agree with your recommendation. The Benefit, Employment, and Support Services Division (BESSD) and the Med-QUEST Division (MQD) have agreed to jointly develop a standard operating procedures (SOP) manual for interaction between the

Divisions. Both Divisions agree that the SOP must be different for Oahu and the neighbor islands to reflect the different operations in the two divisions.

The third recommendation is for the Department to evaluate HAPA to assess the efficacy of shared technology to fulfill information system requirements. We are not opposed to this recommendation, but we believe that our decision to develop the Hawaii Prepaid Medical Management Information System (HPMMIS) and implement this system on November 1, 2002, was a sound one and the benefits will overshadow the initial start-up difficulties identified in your report. As you state in your report, "Hawaii benefited from Arizona's proven and certified system and the ease by which the Arizona system could adapt to Hawaii's needs. In addition, the HAPA system would be serviced by another state's already well established information systems branch." Sharing of compliance activities and costs related to the Health Insurance Portability and Accountability Act (HIPAA) systems requirements have provided significant financial, administrative, and operational benefits for both Arizona and Hawaii.

We wish to point out some statements in the draft report that we believe are not correct or not clear.

- At the end of the 4th paragraph on page 2, the "General Assistance program (GA), and SHIP-eligible recipients" are erroneously identified as Federally protected groups. The two groups were formerly State funded groups and are, therefore, not protected by the Federal government.
- In the second paragraph of page 3, a statement refers to Appendix A which identifies the 12 programs administered by the Med-QUEST Division implying that all of these programs are eligible to receive Federal Medicaid funds, but this is erroneous. The Immigrant Children's Program is a fully State-funded program. The Division also administers a State funded program for women with breast and cervical cancer who are barred from participation in the Medicaid program. The 9-11 Net Program and the COBRA Premium Reimbursement Programs were fully State-funded programs that were discontinued in 2002. The Funeral Payments Program is a State-funded funeral assistance program that is not, in any way, related to medical assistance.

We acknowledge the concerns that you raise in your report and we are committed to implementing as many of your recommendations as practicable given our current and attainable resources. The Department believes that QUEST is an important program enabling the State to capture more Federal dollars and use those additional funds to cover more individuals than would otherwise have been covered under the traditional Medicaid program. Today, QUEST covers approximately 136,000 individuals as compared to approximately 118,000 individuals covered prior to QUEST. In 1994, prior to QUEST, only 30,000 of 118,000 individuals were covered with State funds. Today, a significantly greater population—129,000 individuals—are covered with both State and Federal funds through QUEST.

Honorable Marion M. Higa
May 12, 2003
Page 3

Thank you for your continued cooperation in helping us to identify areas that we can improve to better serve the people of our State.

Sincerely,

A handwritten signature in black ink, appearing to read "Lillian B. Koller". The signature is fluid and cursive, with the first name being the most prominent.

Lillian B. Koller, Esq.
Director