REPORT TO THE TWENTY-SEVENTH HAWAII STATE LEGISLATURE 2015

IN ACCORDANCE WITH THE PROVISIONS OF SECTION 346-54, HAWAII REVISED STATUTES

DEPARTMENT OF HUMAN SERVICES
Benefit, Employment, And Support Services Division
Med-QUEST Division
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REPORT TO THE HAWAII STATE LEGISLATURE 2013 PURSUANT TO SECTION 346-54, HAWAII REVISED STATUTES, ON ASSISTANCE ALLOWANCE AND PUBLIC ASSISTANCE COST CONTROL RECOMMENDATIONS

Section 346-54, Hawaii Revised Statutes (HRS), requires the Director of Human Services to submit a report to the Legislature on or before January 1 of odd-numbered years, concerning the adequacy of the assistance allowance established by chapter 346.

In addition, should general fund expenditures for financial assistance and medical payments increase at a rate greater than the rate of increase in general fund tax revenues in any fiscal year, the Director is to report such increases to the Legislature and make cost control recommendations that will control increases in general fund public assistance expenditures. Cost control recommendations shall include, but not be limited to, the following: (1) changes in eligibility standards, (2) adjustments to the assistance allowance, (3) alternatives to financial assistance for meeting the needs essential to maintaining an adequate standard of living, and (4) adjustments to medical payment fees and levels of service.

FINANCIAL ASSISTANCE

Adequacy of the assistance allowance established in HRS 346

Effective July 1, 2007, the assistance allowance was raised to 50% of the 2006 Federal Poverty Level (FPL) as allowed by statute for all financial assistance programs, Temporary Assistance for Needy Families (TANF), Temporary Assistance for Other Needy Families (TAONF), General Assistance (GA) and Aid to the Aged, Blind and Disabled (AABD). For a household of one, the assistance allowance was $469 per month.

Due to budget constraints, effective July 1, 2009, the assistance allowance was decreased to 48% of the 2006 FPL for all financial assistance programs. For a household of one, the assistance allowance was decreased to $450 per month.

The statute requires adjustment of the assistance allowance to utilize, yet remain within, the appropriation for the given fiscal year. The assistance allowance for the GA program was decreased to $300 a month effective November 1, 2009. This decrease was necessitated because the financial assistance caseload increased from 4,728 in July 2008 to a high of 5,265 in March 2009. The decrease in payment caused the caseload to decrease in fiscal year 2010 to 4,778 in June 2010. Therefore, effective July 1, 2010, the payment was increased to $353 a month. Effective October 2011, the payment was decreased to $319 because the caseload increased to an average of 5,298 in FY 2011. Effective February 2013, the payment decreased to $298 because the caseload had risen to 5,833 in the first quarter of FY 2013. Effective October 2013, the payment increased to $319 due to slight decline in the caseload. Due to the continuing decline in caseload, the payment was increased again to $348 effective April 2014.

The assistance allowance for the AABD program was decreased to $319 a month effective June 2010 due to budget constraints. Since the decrease to $319, the caseload also decreased to an

average of 859 cases in FY 2012. The average caseload in FY 2014 was 868 cases. Effective April 2014, the payment increased to $348 to align with the GA assistance payment.

Increase of State general fund expenditures for financial assistance that increase at a rate greater than rate of increase in general fund tax revenue in any fiscal year

The general fund expenditure for financial assistance has been as follows:

Program	FY 2012		FY 2013		FY2014	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
TAONF	2,039	$13,624,686	1,978	$12,065,596	1,630	$10,465,815
GA	5,537	$21,827,623	5,722	$21,483,843	5,465	$21,396,090
AABD	859	$3,115,324	898	$3,288,333	868	$3,239,956

Cost control recommendations to control increases in general fund public assistance expenditures

1) Changes in eligibility standard:

TAONF: July 1, 2009, net income standard decreased to 48% of 2006 FPL or $450 per month for one person. Gross income standard has been $1,737 for one person as of July 1, 2007.

GA: November 1, 2009, net income decreased to 32% of 2006 FPL or $300 a month for one person. July 1, 2010, it increased to 37.6% of FPL or $353 a month for one person. October 1, 2011, net income decreased to 34% of FPL or $319 for one person. February 1, 2013, it decreased to 31.7% of FPL or $298 for one person. Gross income standard has been $1,737 for one person as of July 1, 2007.

AABD: July 2010, net income decreased to 34% of 2006 FPL or $319 a month for one person. Gross income standard has been $1,737 for one person as of July 1, 2007.

2) Adjustments to assistance allowance:

TAONF: July 1, 2009, it decreased to 48% of 2006 FPL or $450 per month for one person.

GA: November 1, 2009, it decreased to 32% of 2006 FPL or $300 a month for one person; July 1, 2010, it increased to 37.6% of FPL or $353 a month for one person; October 1, 2011, it decreased to 34% of FPL or $319 for one person; February 1, 2013, it decreased to 31.7% of FPL or $298 for one person; and April 1, 2014, it increased to 37.1% of FPL or $348 for one person.

AABD: July 1, 2010 it decreased to 34% of 2006 FPL or $319 a month for one person and April 1, 2014, increased to 37.1% of FPL or $348 for one person.

3) Alternatives to financial assistance to meet the needs for an adequate standard of living:

We continue to have all individuals who claim a disability examined by a contracted medical provider. All medical examinations are then reviewed by a contracted medical board. This process is implemented statewide and has standardized the definition being used to determine if a person is disabled and eligible for this program. All those needing assistance are now being assessed through the use of a consistent standard.

We also continue to contract for Social Security advocacy services to maximize the number of people eligible for federal assistance. The Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) advocacy program, through sub-contracts with the Legal Aid Society of Hawaii (LASH) continues to assist disabled individuals receiving federal TANF assistance, and eligible State-funded individuals in the TAONF, GA, and AABD programs, to qualify to receive SSI federal benefits. The federal SSI/SSDI benefits are higher than our state-funded cash benefits, and are not time-limited.

In FY 2012, 391 individuals were approved for federal SSI/SSDI. In FY 2013, 342 individuals were approved for federal SSI/SSDI and in FY 2014, 319 individuals were approved for federal SSI/SSDI.

In December 2012, the Hawaii Automated Welfare Information (HAWI) payment system was modified to automate the interim assistance reimbursement (IAR) notification to the Social Security Administration (SSA). Under the IAR program state funded assistance is issued to SSI claimants while the application for SSI is pending. If the SSI application is approved, the SSA will retroactively reimburse Hawaii for the state-funded assistance provided to the individual. Prior to this modification, a manual hard copy IAR agreement was sent by FAX or U.S. mail to the SSA. There were multiple problems with this manual process, such as non-receipt, misfiling and transmittal to the incorrect SSA field office. The modification has made the program more efficient and helps ensure that the State receives the federal reimbursements from the SSA.

These procedures have been instrumental in transferring persons with long-term disabilities to the federally-funded SSA programs.

MEDICAL PAYMENTS

Medicaid is counter-cyclical, meaning that as the economy worsens the number of beneficiaries increase. Medicaid is an entitlement program where any individual who is categorically eligible must be provides services. The Med-QUEST Division (MQD) provides health coverage through several Medicaid programs under Title XIX of the Social Security Act. The health insurance coverage includes the Hawaii QUEST Managed Care (QUEST), the Hawaii QUEST Expanded Access managed care (QExA) and the Medicaid Fee-For-Service (FFS) programs. Other smaller health insurance programs include the State Children's Health Insurance program (S-CHIP), Federal and State-funded Coverage of Individuals with Breast and Cervical Cancer, and Special Programs for Medicare Beneficiaries.

With the implementation of the Patient Protection and **Affordable Care Act** (2010) (ACA), Hawaii provides medical assistance to low income adults, parent/caretaker relatives, pregnant women and children utilizing new eligibility methodology called Modified Adjusted Gross Income (MAGI).

Health care inflation for services tends to be higher than inflation of non-health care items, such as the consumer price index. Health care inflation results from increased utilization of more expensive services such as new drugs, devices or procedures. In general the Hawaii Medicaid program has been able to keep inflation low and the major cost driver has been due to increased enrollment. Over the past 4 years enrollment has increased approximately 22%. The following table provides the enrollment and expenditures.

	SFY 2011	**SFY 2012**	**SFY 2013**	**SFY 2014**
Total Expenditures	$1,624,665,399	$1,580,549,010	$1,895,933,438	$2,030,231,193
General Funds	$549,219,050	$774,151,967	$906,243,996	$912,512,932
Federal Funds	$1,075,446,349	$806,697,043	$989,689,442	$1,117,718,261
Beneficiaries	266,625	283,041	292,423	325,510

The hospital and long term care sustainability fees programs were implemented in SFY 2013 and have provided these facilities with new revenue. The hospitals will be assessed a total of $131,216,623 through the current fiscal year and will receive a total of $243,465,421 in additional reimbursements since inception of the program. The long term care facilities will be assessed a total of $33,318,831 through this fiscal year and will receive a total of $63,607,281 in additional reimbursements since inception in SFY 2013. The department retains a portion of the fees collected, and which are used by the Department to increase and improve services for Medicaid program recipients.

Effective January 1, 2015, the MQD will be combining the QUEST and QExA into one program called QUEST Integration (QI) . It has taken more than two years to plan and implement the program and will benefit both recipients and providers. QUEST Integration will reduce the administrative burden for health plans, providers and the State, while streamlining the application process and access to care for applicants and recipients. Health care services provided under the capitated health care plans have demonstrated a more predictable and slower rate of expenditure growth while establishing contractual accountability by the health plans and providers.

With additional positions to conduct increased program integrity activities, the MQD has implemented new federally required contracts to assist with identification and recovery of overpayments. While the MQD has more work to do in this area, it has identified $886,512 as potential overpayments through review of claims payment reports. For the past SFY, we received $134,702 in repayments and referred six cases to the Medicaid Fraud Control Unit of the Department of Attorney General for further investigation.

The implementation of the new eligibility system, Kauhale On-Line Eligibility Assistance (KOLEA) has allowed increased efficiency by automating many of the functions previously

performed manually. With KOLEA, the MQD met the increase in statewide enrollment of 11% from 292,423 to 325,510 due to new federal ACA regulations, and made 463,000 eligibility determinations and re-determinations in one year. The MQD made 22,000 determinations within 24 hours through KOLEA. Further enhancements to KOLEA will allow the MQD to move toward a paperless work environment and will increase access to recipient and applicant information by any MQD worker statewide.

These efforts have allowed the MQD to operate within its appropriation while increasing benefits in certain areas such as behavioral health and home and community-based services.