Update from the Med-QUEST Division

November 19-20, 2014

Agenda

- Part I
  - Status of Citizens of COFA Nations
  - QUEST Integration
  - Kupuna Care
  - Working Disabled Adults
- Part II
  - KOLEA
  - School-Based Claiming
  - Adult Dental
  - Health Home

Start Part II

Affordable Care Act (ACA)

- Expanded access to affordable health insurance
- Provided a continuum of Medicaid and sliding scale tax credits based on income
- Requires use of Modified Adjusted Gross Income (MAGI) for certain groups
  - Medicaid: Children, pregnant women, parents and other caretaker relative, certain adults
  - Connector: Tax credits, cost share reduction

MAGI

- Exchange application of MAGI is described in 45 CFR 155.305:

  (f) ***Eligibility for advance payments of the premium tax credit.***

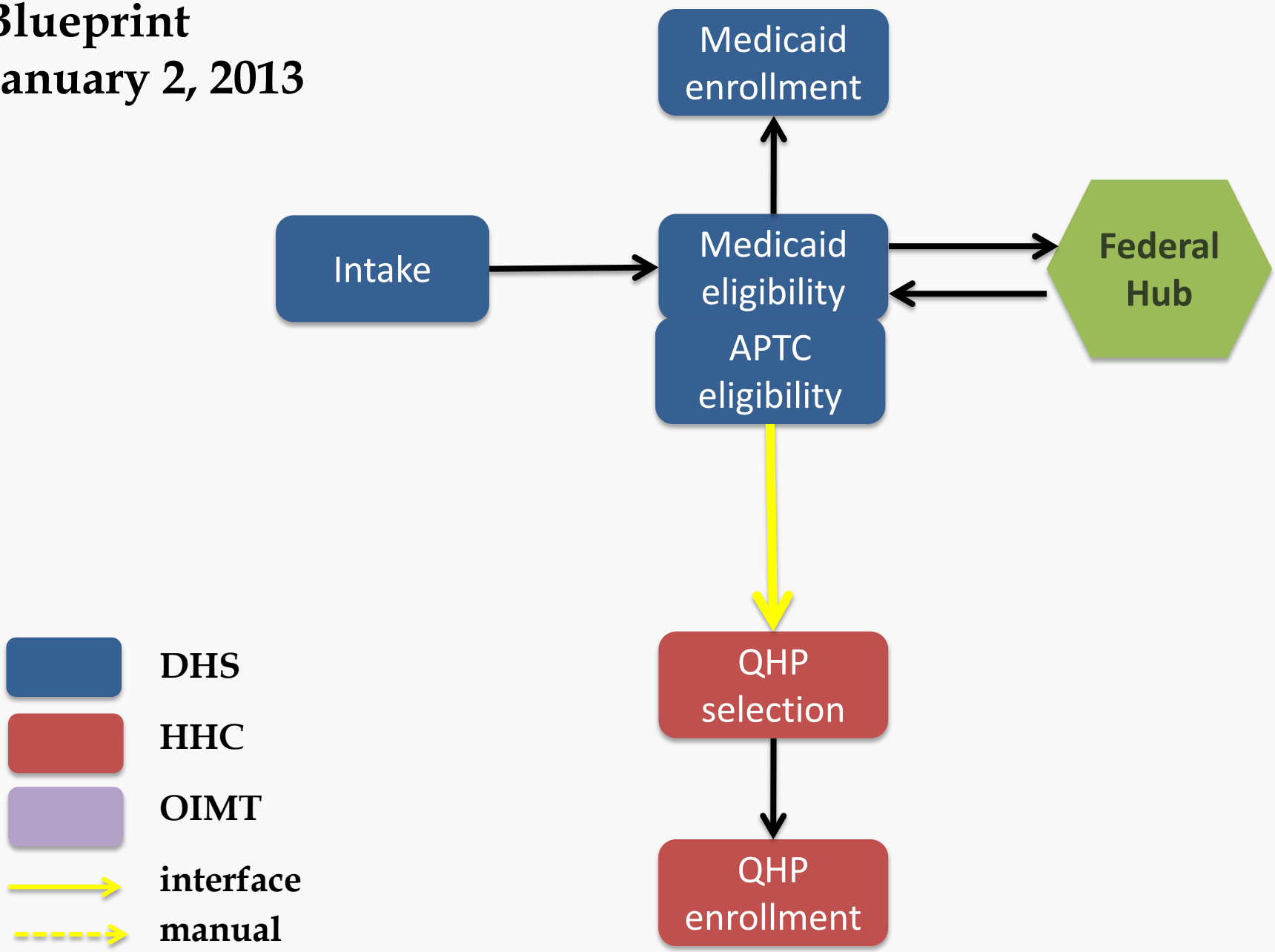
  (1) ***In general.*** The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

  (i) He or she is expected to have a household income, as defined in section 36B(d)(2) of the Code, of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

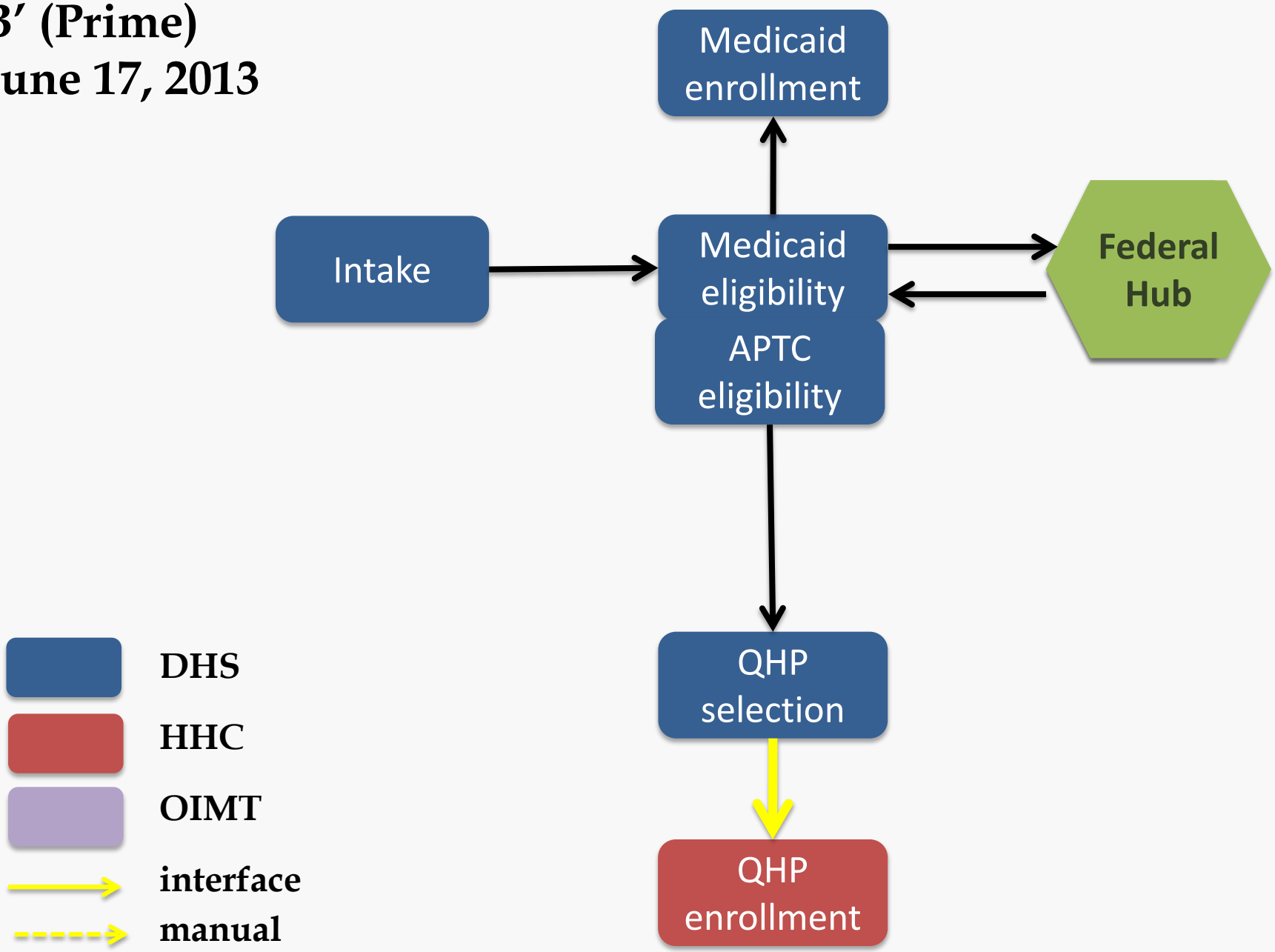
- The Medicaid application of MAGI is described in 42 CFR 435.603:

  (e) ***MAGI-based income.*** For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

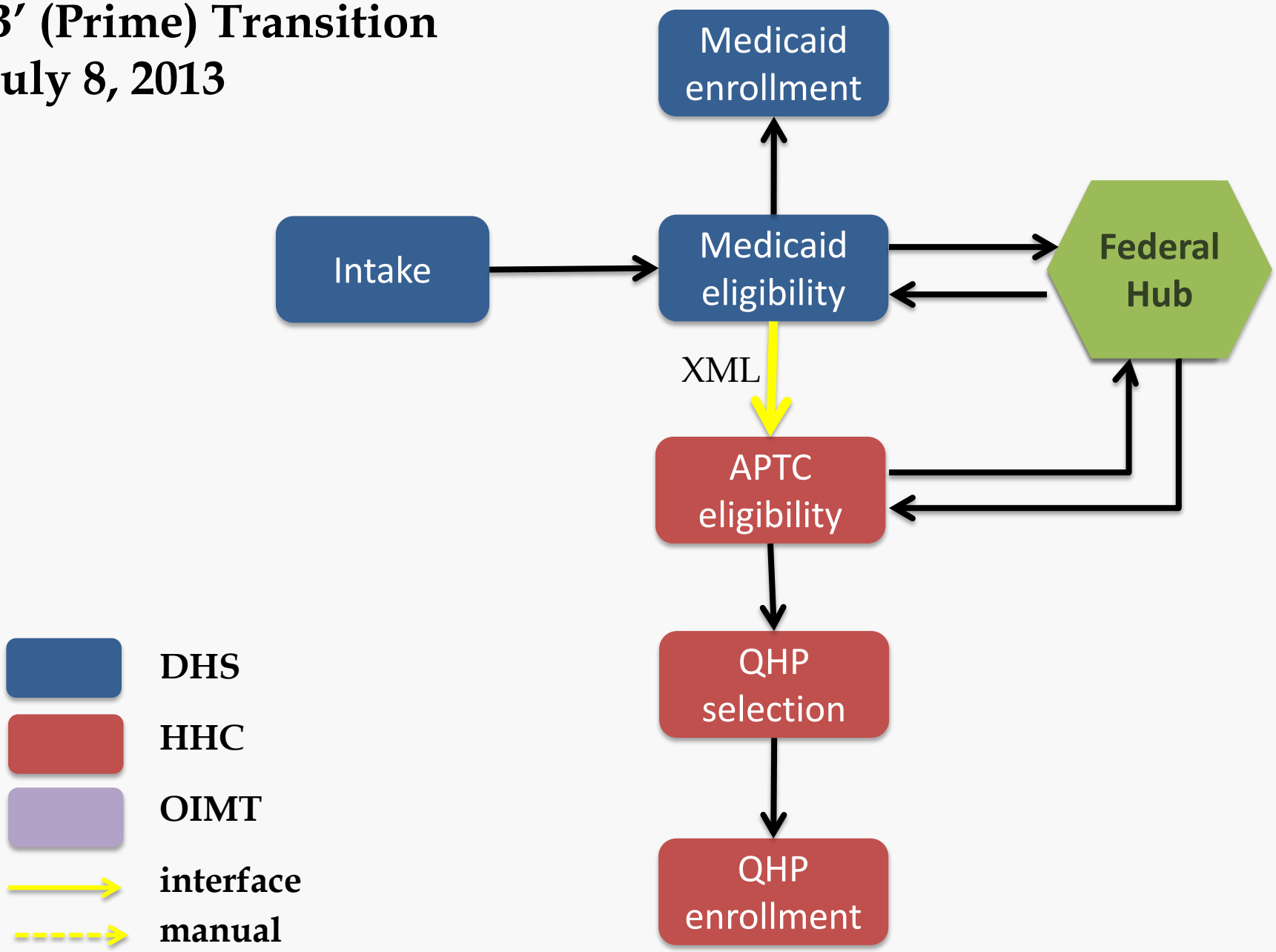
Blueprint
January 2, 2013



B′ (Prime)
June 17, 2013



B' (Prime) Transition
July 8, 2013



Background

- To comply with ACA requirements, MQD needed to implement a new eligibility system
  - Existing 25 year old legacy system could not support
- Medicaid eligibility systems typically take 3-5 years to implement
- MQD began work in January and was able to go live October 1, 2013
  - Required prioritizing functionality

System Problems

- System integrator (SI) used pre-configured software as an accelerator
- This accelerator did not support Medicaid business requirements and could not automatically process:
  - ~290,000 converted individuals from HAWI
  - Applications that were missing fields
  - Change in circumstance
- SI configured system to the extent possible to address accelerator flaws
- Remaining burden fell on MQD eligibility workers
  - Change of circumstance

State of Hawaii
MyBenefits

search this site

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- Am I Eligible?
- Apply for Benefits
- Access MyBenefits
- Need a Language Interpreter?

NEWS

Department of Human Services Implementing New System
Posted on August 28, 2013

New Single Streamlined Application Effective October 1, 2013
Posted on August 28, 2013

INFORMATION

- Applying for Benefits
- Required information to complete an application
- Receiving Benefits
- Appeals

PROGRAMS

- Overview of Medical Assistance

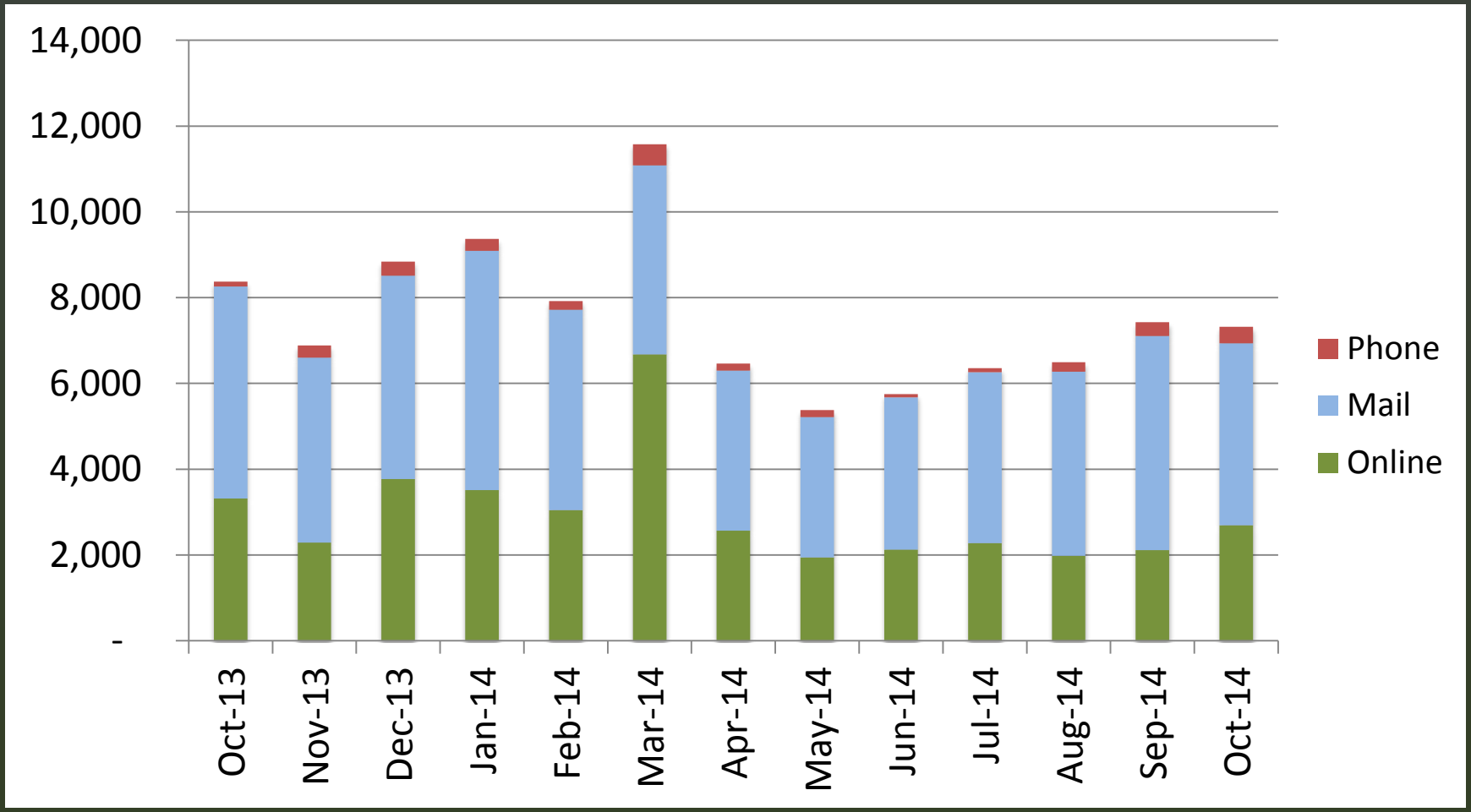
NEED HELP?

- Portal User Guide
- Hawaii Health Connector
- Med-QUEST Office Contact Information
- The Connector Assisters & Navigators
- Frequently Asked Questions (FAQs)

Applications

- DHS must accept an application if it contains a name, address, and signature
- Applications can be submitted:
  - Hardcopy by mail or fax sent to DHS
  - Electronically online at mybenefits.hawaii.gov (KOLEA)
  - Telephonically by calling the Hawaii Health Connector
- Paper applications must be manually entered into KOLEA for KOLEA to make determination
- Online applications are more quickly, and can be automatically, processed

98,000 Household Applications Received



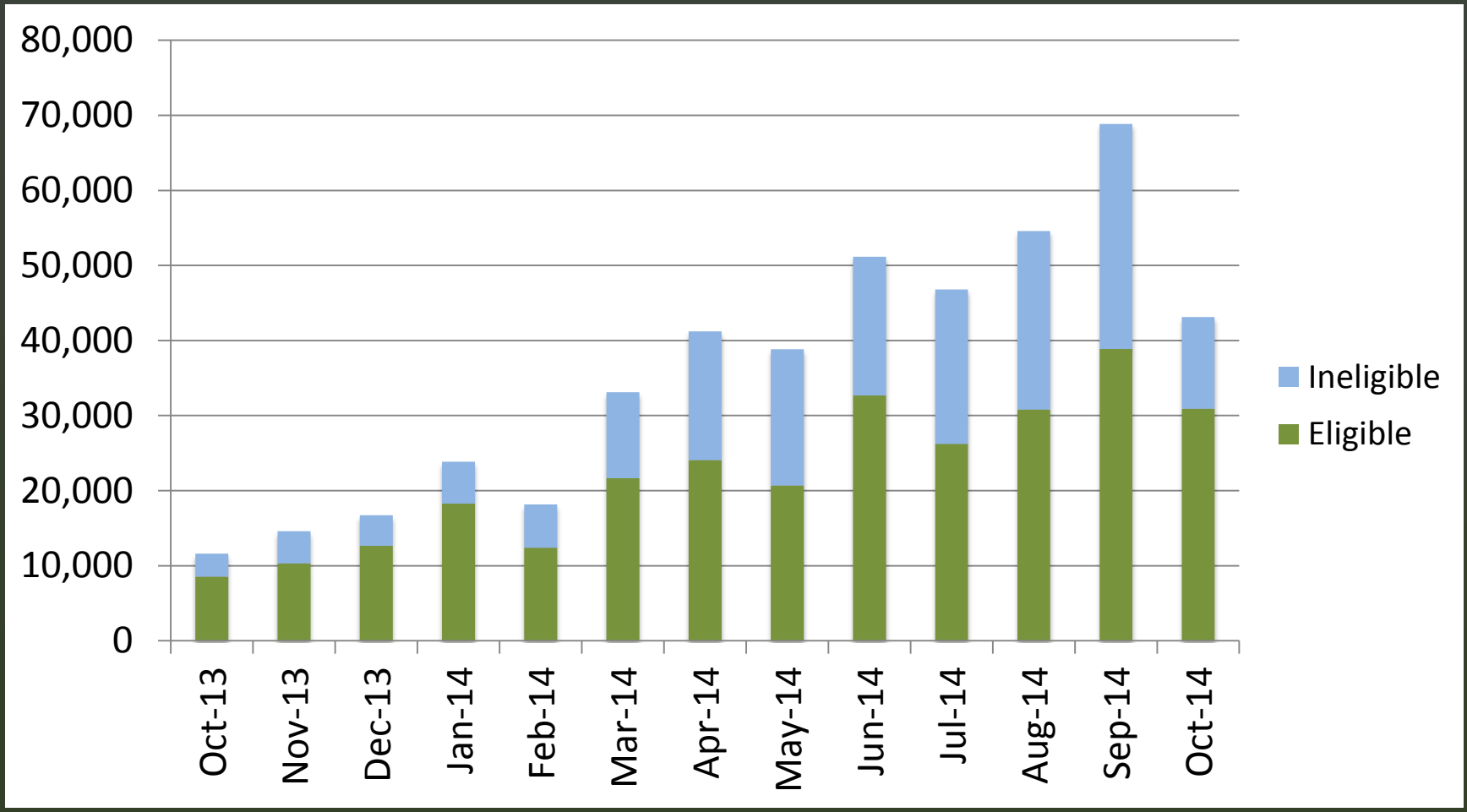
Increasing Online Applications

- Connector Marketplace Assisters
  - Must execute business associate agreement (BAA) with Connector
  - Must complete privacy/security training
- Hospitals and FQHCs
  - Must execute BAA with DHS
  - Must complete privacy/security training
  - Must return completion documentation to DHS

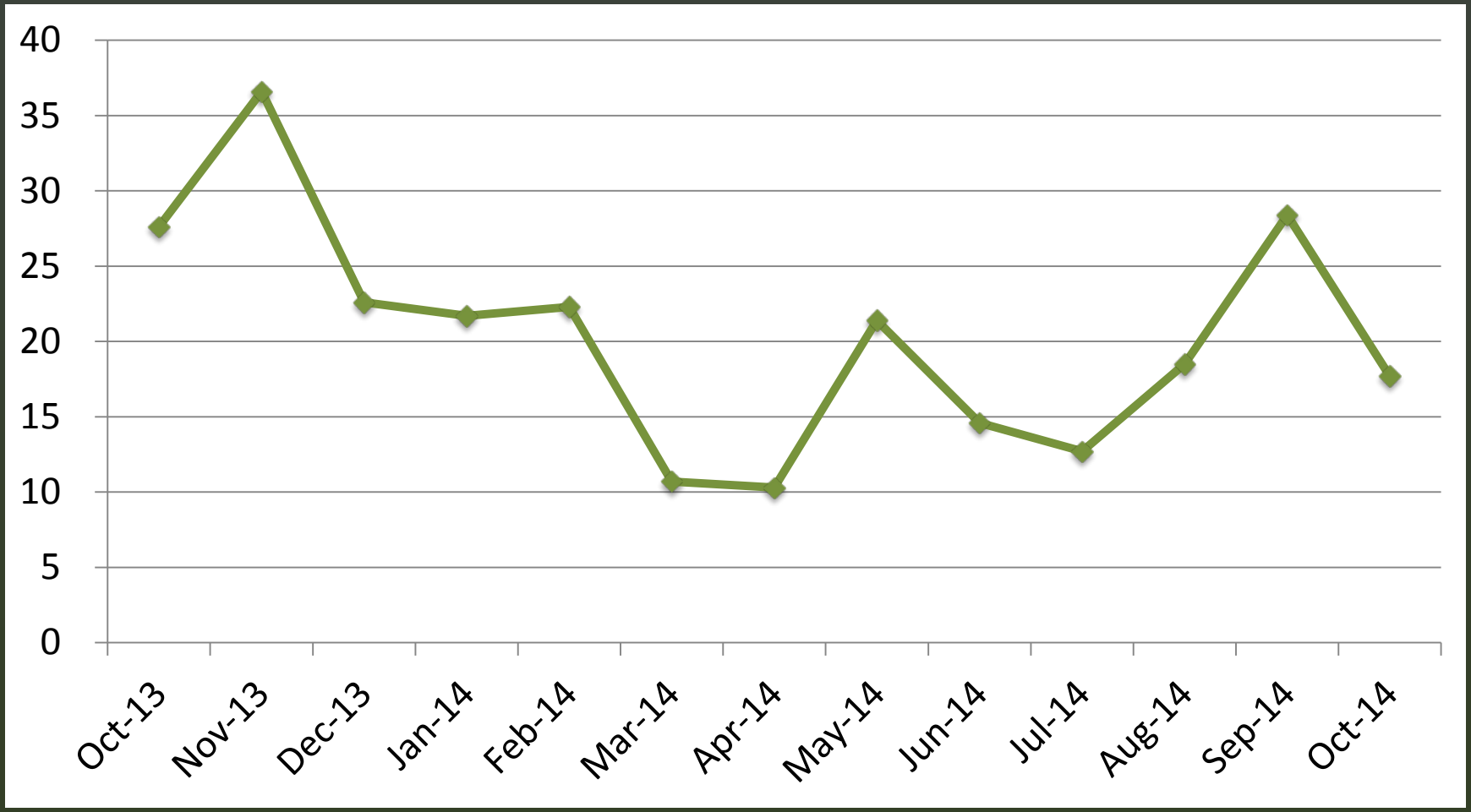
Access to Assist Online Applications

Provider with executed BAA	# staff trained	# staff with KOLEA access
Kuakini	0	0
HPH/KMCWC	7	0
Koolauloa CHC	1	1
Molokai CHC	0	0
Kalihi-Palama CHC	5	5 (in progress)
Waikiki CHC	2	2
Waimanalo CHC	5	1

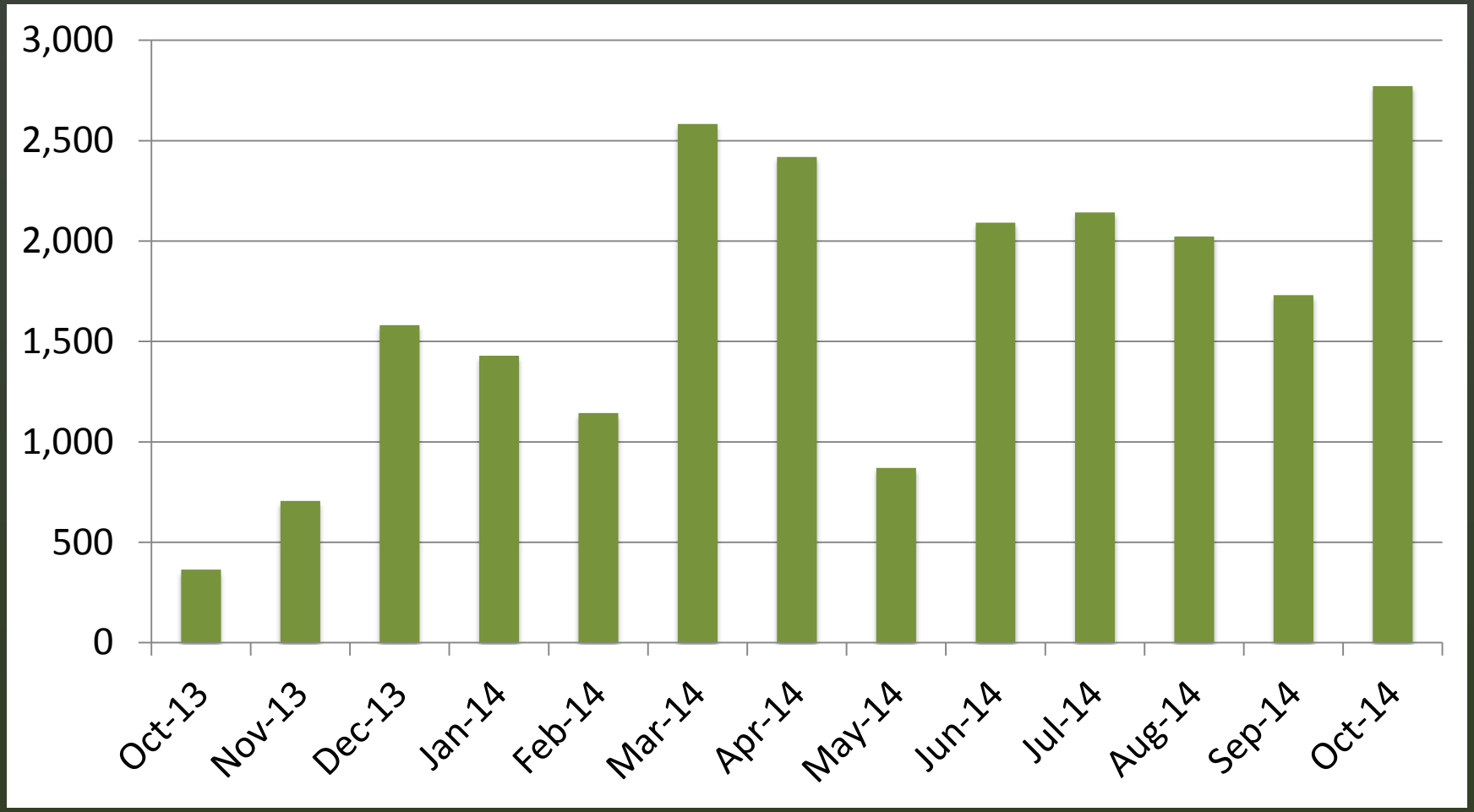
463,000 Eligibility Determinations and Redeterminations Made



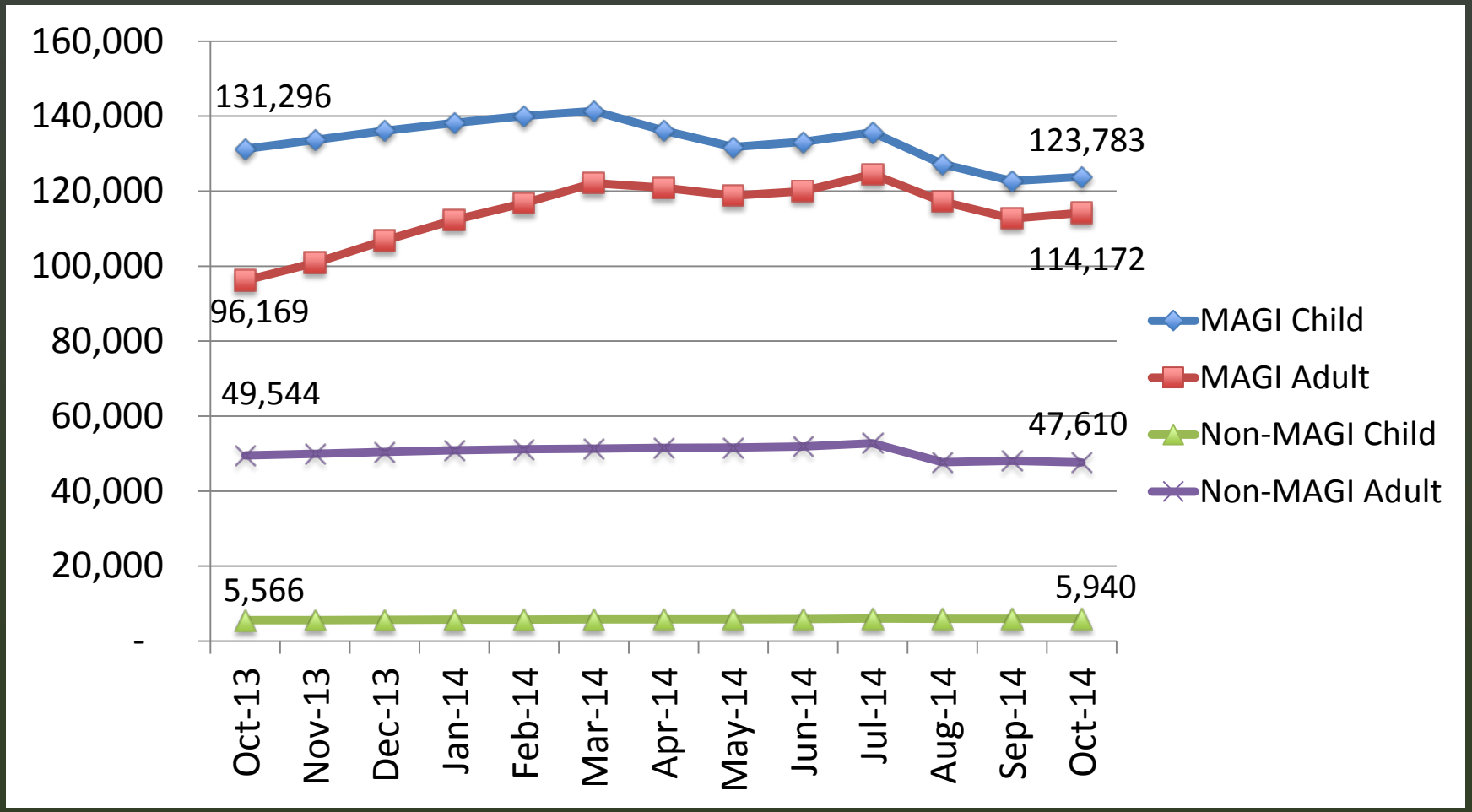
Decreasing Average Processing Time for MAGI Determinations



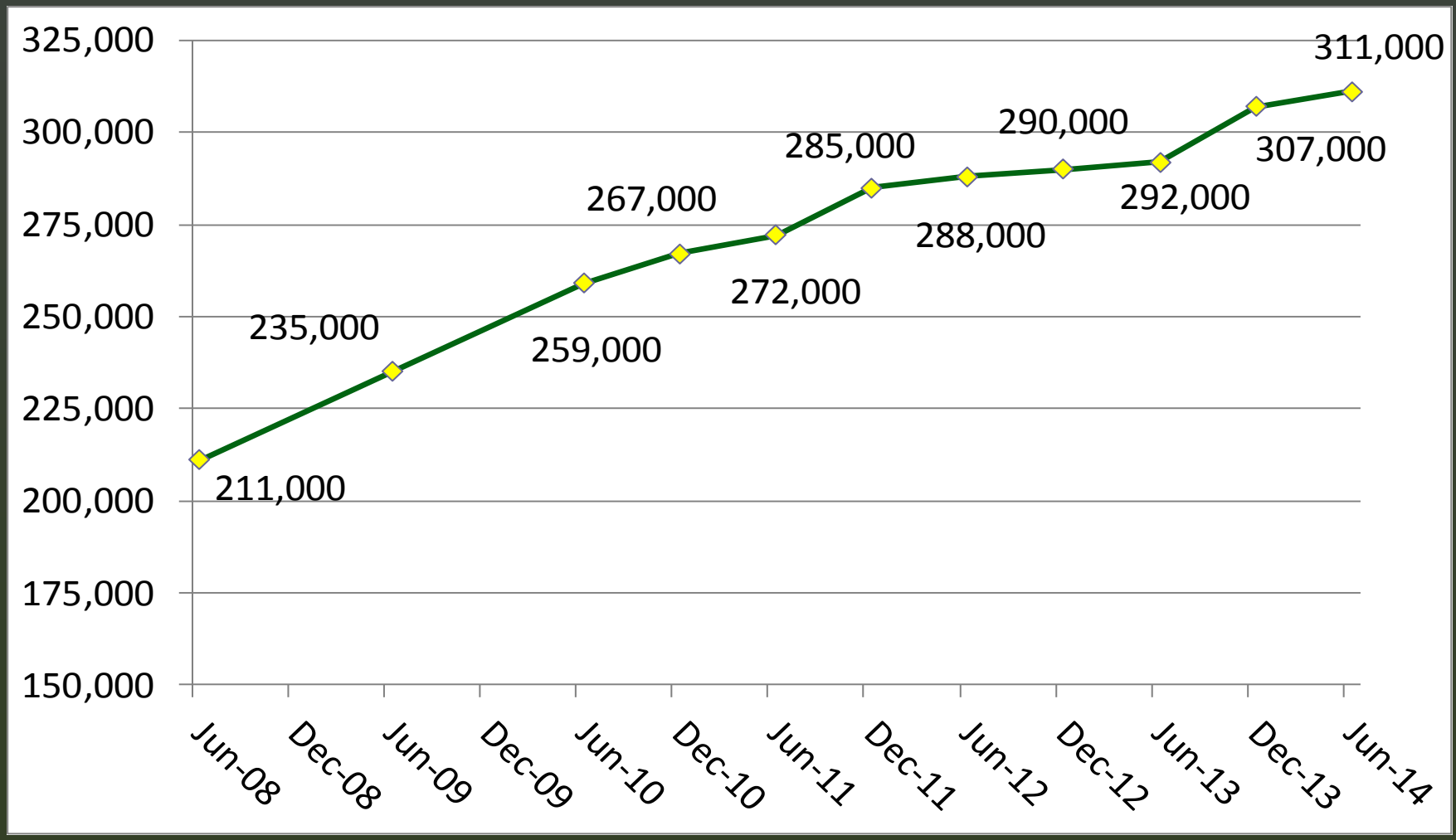
22,000 MAGI Application Determinations Made in ≤24 Hours



18,000 Increase in MAGI-Adults



47% Increase in Enrollment 2008-2014



Eligibility Renewal (ER)

- Under the ACA, Medicaid eligibility is redetermined based on available data
  - Tax information is required for MAGI determination
- MAGI groups (non-ABDs) received 6-month eligibility period extension with ERs resuming Apr 2014
  - All MAGI beneficiaries renewed Apr – Sept 2014
- MAGI excepted groups (ABDs) began passive renewal Oct 2013
- Beginning Oct 2014, all MAGI and MAGI excepted beneficiaries receive passive renewal

Outreach on Eligibility Renewal

- Added renewal date to health plan ID cards and DMO
- Held public briefing
- Posted Q&A on MQD website
- Sent letter to providers
- Required health plans to do outreach
- Send households three letters
  - "Heads up", ER packet, termination notice
- Placed radio ads
- Sent info package/posters to homeless shelters, FQHCs
- Posted ads on community TV bulletin boards

Lost Eligibility

- Any individual who lost eligibility for not returning their ER form is strongly encouraged to reapply
- Applications will be processed the quickest if submitted online
- Eligibility can be retroactive up to 10 days
- We are working on policies and procedures to facilitate reapplication process for those who lose eligibility due to whereabouts unknown

Release 2, Wave 1

- Occurred in April, main addition was long-term care functionality
- The MAGI-excepted rules are more complex than the MAGI rules
- Long-term care (LTC) is among the most complex of the MAGI-excepted related rules
- LTC eligibility requires financial and clinical eligibility, both of which must be renewed at least annually

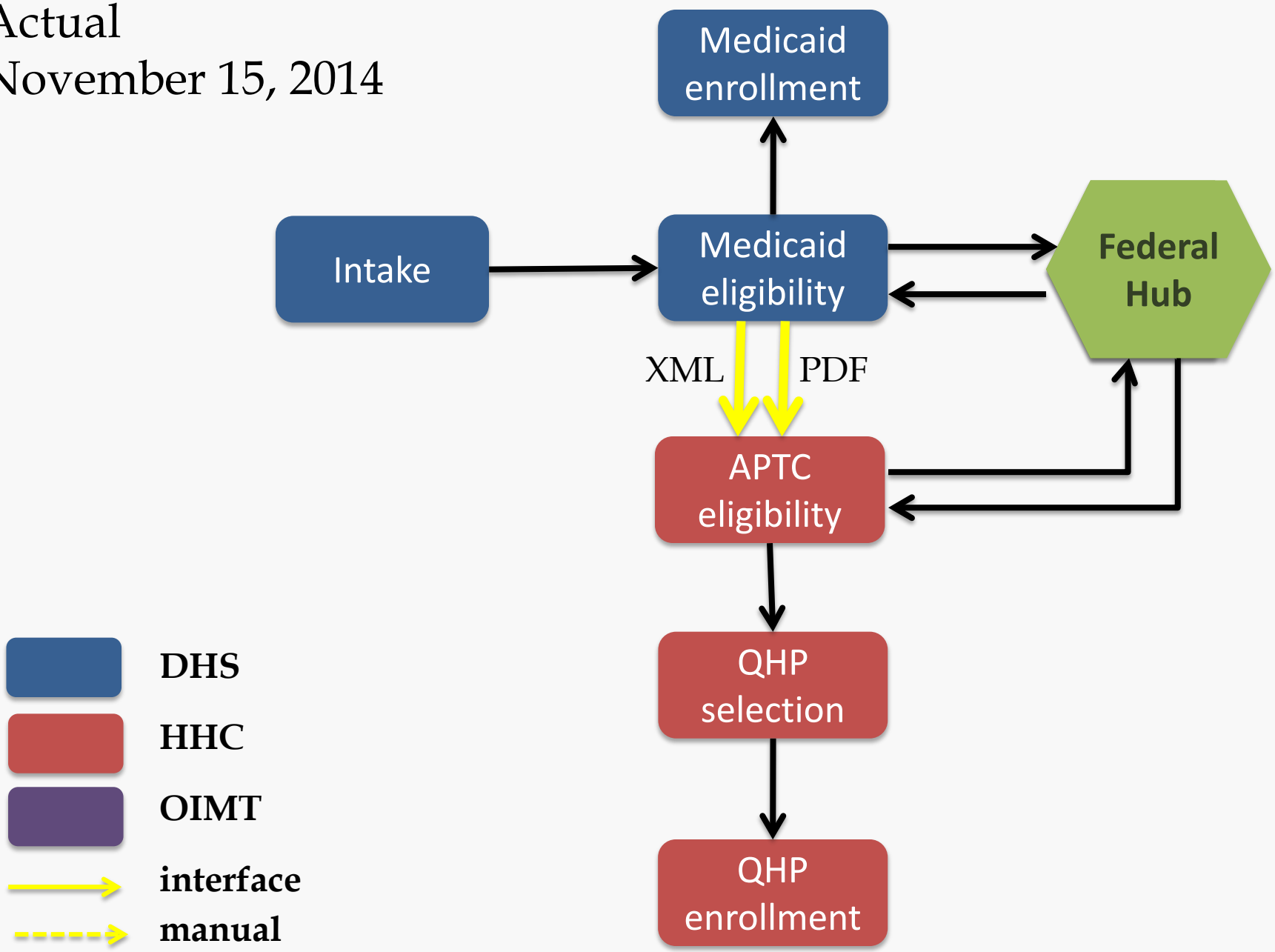
Cost-share

- Individuals who are over income and receiving LTC services have a cost share
- The calculation of a cost-share requires:
  - Financial eligibility
  - Clinical eligibility (approved 1147)
  - Facility code
  - Living arrangement code
  - Medicaid Management Information System (MMIS)
- We have had system problems with cost-share, but worked closely with LTC providers and have resolved

Release 2, Wave 2

- Planned for this fall but postponed to January 2014 to support OIMT's plan for open enrollment
- Completes separation from the accelerator
  - Reduces manual work-arounds by eligibility workers
- Adds capability for beneficiaries to report circumstance changes through self-service
- Adds enterprise content management
- Completing testing and beginning training

Actual
November 15, 2014



Questions?

School-Based Claiming

- Services provided by DOE to children who have Medicaid can be considered Medicaid services
- Provider must be licensed or certain unlicensed provider under supervision of licensed provider
- Services must be available to all children statewide
- DOE uses the University of Massachusetts as a consultant to help prepare requests

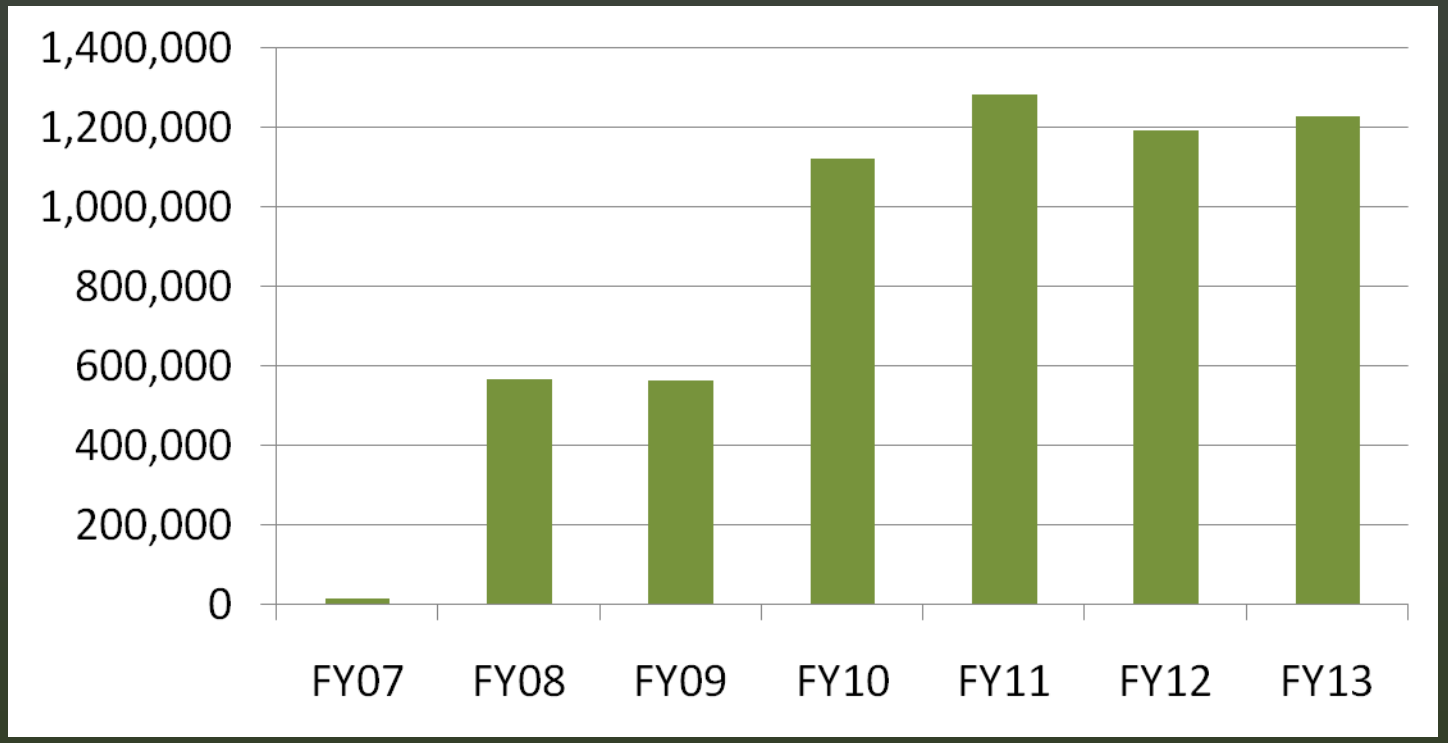
School-Based Claiming

- MQD currently covers the following:
  - Physical therapy, occupational therapy, speech language therapy services
  - Assistive technology device services and therapy
  - Hearing, audiology, and language services
  - Nursing services
  - Behavioral health services
- Requires documentation in Individual Education Plan

School-Based Claiming

- DOE is requesting that additional services be covered
  - Transportation
  - Psychologists (unlicensed)
  - Intensive behavioral therapy
  - Administrative claiming

U Mass: Revenue from Inception



U Mass: Opportunities

- Nursing has been approved to research for claiming by the DOE; currently cost benefit analysis is being conducted.
- Expedite efforts to approve claiming for Medical Management, Psychiatric Medical Evaluation, and Psychiatric Diagnostic Evaluation.
- Improving the process of obtaining more health professional credentials is the single largest opportunity to increase Hawaii School-Based Medicaid claiming. The Center estimates improving the process would have potentially resulted in an increase of 263 providers, which would have increased reimbursement revenue by nearly $1.9M over the past two years.
- Continuing efforts to obtain more parental consents.
- Initiate Administrative Activity Claiming.

Questions?

Adult Dental

- MQD covers:
  - Full dental benefits for children
  - Emergency dental benefits for adults
- The Governor's budget request included $4 M to restore the adult dental benefit
- The Legislature appropriated $1.5 M
- Given demand and uptake, MQD estimates $1.5 M would fund 3 months of coverage
- MQD is making preparations to restore the adult dental benefit for April 1 – June 30, 2015

Adult Dental

- Restoration requires release of funds by next Governor
- Decision might consider likelihood of funding next year
- If limited to 3 months, considerations include:
  - Benefit to those who receive needed care during the period
  - Confusion to patients and providers
  - Challenges with extended treatment plans
  - Compressed demand exceeding provider supply
  - Administrative work to start and stop
- MQD has included $4.8 M general funds in its budget request

Children's Dental

- Hawaii does not have community water fluoridation
- MQD expanded coverage of topical fluoride to include application by PCPs
- Pay $4.16 per application; national average $15-$20
- Would like to increase reimbursement to $18
- MQD included $400K general funds in its budget request for topical fluoride payment increase

Sovaldi

- New treatment for hepatitis C
- Appears very effective
  - But no long term data and studies had limitations
- Complications of hepatitis C develop over decades
- Cost $1,000 per pill (~$90,000 per treatment)
- MQD spent $6 M general funds in first six months of year, requesting $13 M general funds in budget

PCP Reimbursement Enhancement

- MQD paid PCPs at ~60% of Medicare rates
- Under ACA section 1202, required states to pay at 100% Medicare rates, and difference was 100% federally funded
  - Specifies eligible services
  - Includes medical sub-specialists
  - Excludes neurologists, psychiatrists, ob-gyns, APRNs, CHIP
- Enhancement is a reconciliation and based on quantity of care
- This provision lasts 2 years and ends Dec 31, 2014

PCP Reimbursement Enhancement

- Legislature appropriated funding at typical FMAP to maintain current increased reimbursement
- CHIP reauthorization bill includes provision to extend
- Planning to continue current approach through June 30, 2014
- Have budgeted for biennium

Options

- Continue current providers and services
  - At 100% Medicare
- Continue current services, expand to all providers
  - At 85% Medicare
- Expand services (OB, BH), expand to all providers
  - At 75% Medicare
- Begin a per member per month (pmpm) access payment to assigned PCP with a lower % Medicare fee schedule
  - In the future could tier pmpm based on patient panel acuity, have add-on for EHR meaningful use, and have payment component for outcomes

Additional Funding Required

% Medicare rates	80%	85%	90%	95%	100%
Current services, Current providers	--	--	--	--	$0
Current services, Expanded Providers	--	--	$0	$6 M	$13 M
Expanded services, Expanded providers	--	$3 M	$12 M	$20 M	$29 M

- Amounts reflect total funding, approximately 50% federal
- $37 M included in budget for next year
- Each $1 pmpm PCP access payment would cost $1.9 M

Questions?

Health Home

- The Affordable Care Act included provision for Medicaid health home
- No mandatory start or end date
- 17 states have implemented
- Some flexibility with provider type/criteria
- Patient eligibility is based on conditions
- Conditions can only be used once and funding is available for 2 years
- Provider payments receive 90% match, admin 50%

Health Home Services

- Comprehensive Care management
- Care coordination
- Health promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services
- Use of health information technology

Patient-Centered Medical Home (PCMH) Services

- Patient-centered
  - Refer to community resources/supports as indicated
- Comprehensive
  - Be responsible for addressing the vast majority of physical and behavioral health needs
  - Provide preventive, acute, and chronic care
- Coordinated
  - Provide or ensure provision of care across health care spectrum of services and settings
  - Facilitate transition of care and reconcile service plan
- Performance Measurement
  - Utilize electronic health record with registry functionality

CMS's Distinction between PCMH and Health Home

- "…to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care…"

- "CMS encourages states… to design this option to complement those [existing medical home initiatives, including those that utilize private insurance, Medicare, and multi-payer funding streams] initiatives."

Health Home

- The Legislature appropriated funds for a FQHC health home initiative
  - $1 M CHC special funds as State share for benefit
  - $1 M CHC special funds as State share for admin
- CHC special funds must be used for services and cannot be used for admin
- HPCA has continued to provide leadership on preparing a SPA for FQHCs
- MQD Medical Director has been working with HPCA

Proposed FQHC Health Home

- Patients with two or more of the following:
  - Anxiety
  - Asthma
  - COPD
  - Depression
  - Diabetes
  - Heart failure
  - Tobacco use

- Would this be limited to Medicaid beneficiaries, i.e. not those enrolled in state-funded ABD program since not eligible for federal matching funds?

Health Home Summary

- MQD appreciates and recognizes the work done by the HPCA to develop a SPA
- Funding to administer is necessary to proceed
  - Develop operations, evaluation
- DHS has included in its budget request $2 M for benefit and $1 M for admin, both general funds
  - To leave option to expand to non-FQHC providers

Health Home Opportunity

- A vision for delivery system innovation can guide investment into infrastructure development
- Health home is an opportunity to leverage federal funding to advance healthcare transformation
- Opportunity can be used to advance specific policy goals
  - Medicaid specific
  - Statewide general

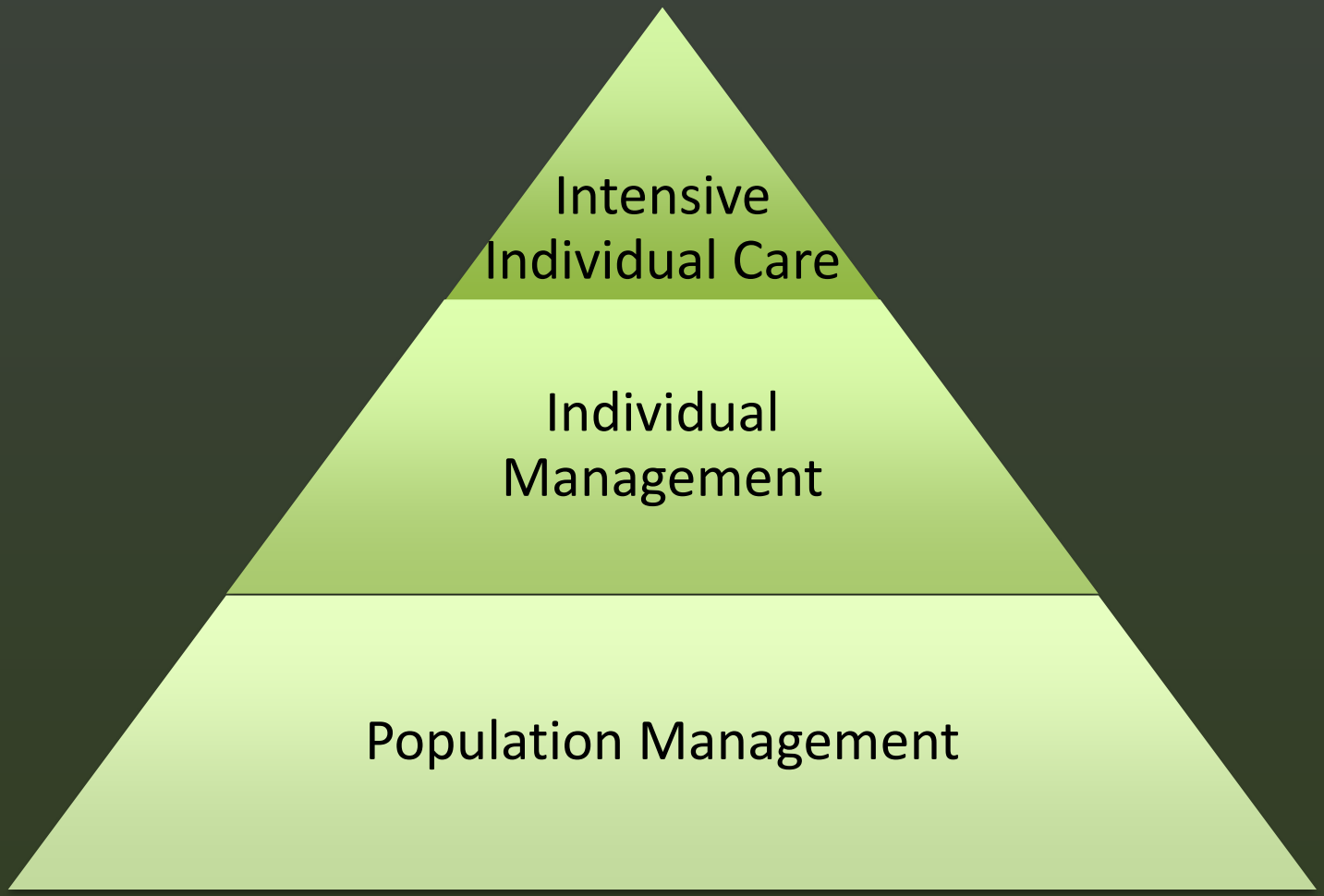
Example of a Medicaid Specific Policy Goal

- Improve integrated delivery of medical and behavioral healthcare for individuals with a serious mental illness
- Allow FQHCs and CMHCs to be eligible providers
- Require co-location of medical and behavioral health services, incorporate substance abuse services
- Develop transitions for individuals released from State Hospital or prison

Example of a Statewide General Policy Goal

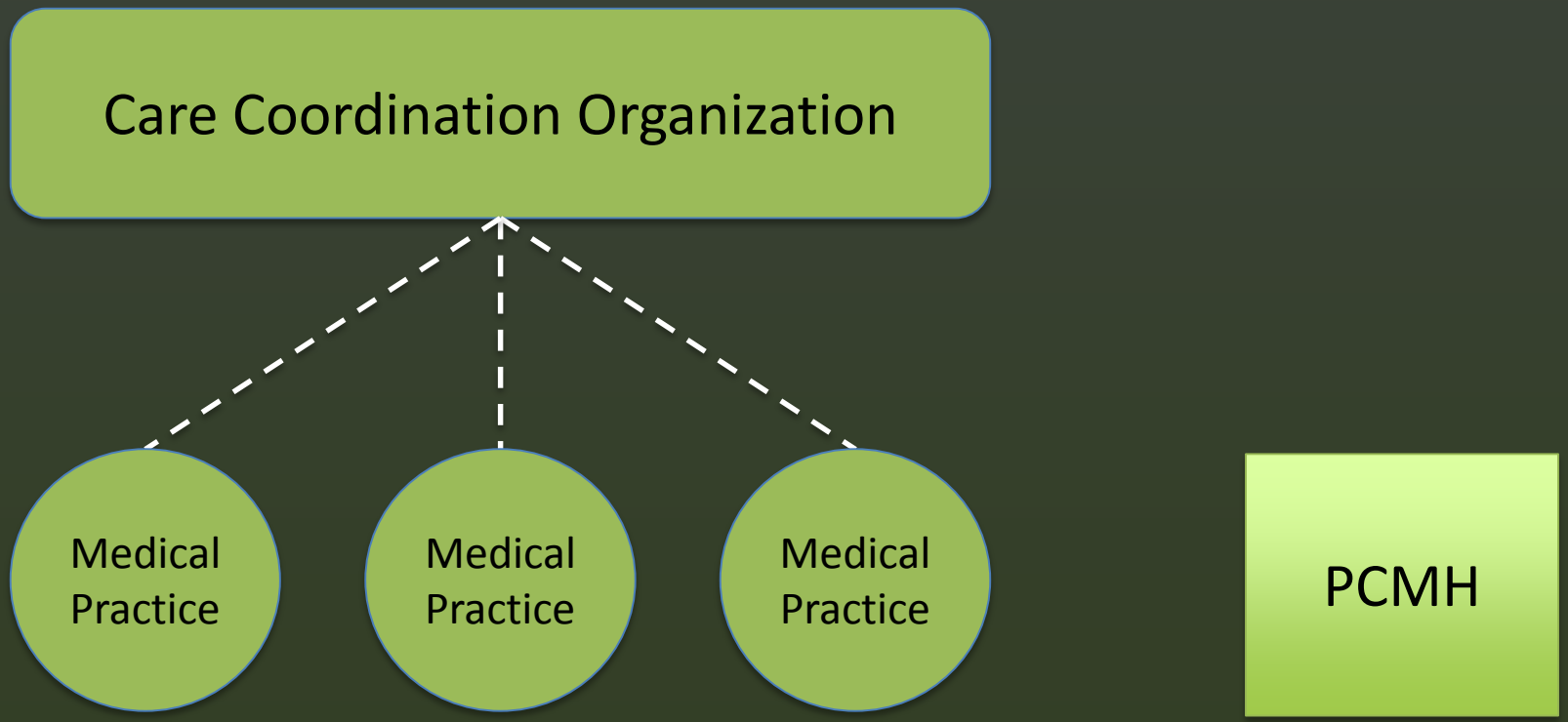
- Opportunity can be used to develop a new capacity to provide wrap-around services to support PCPs
- PCPs can focus on individual management and refer for additional patient-centered supports
- New capacity can perform population management
- Will require functional health information exchange

Layers of Healthcare Services

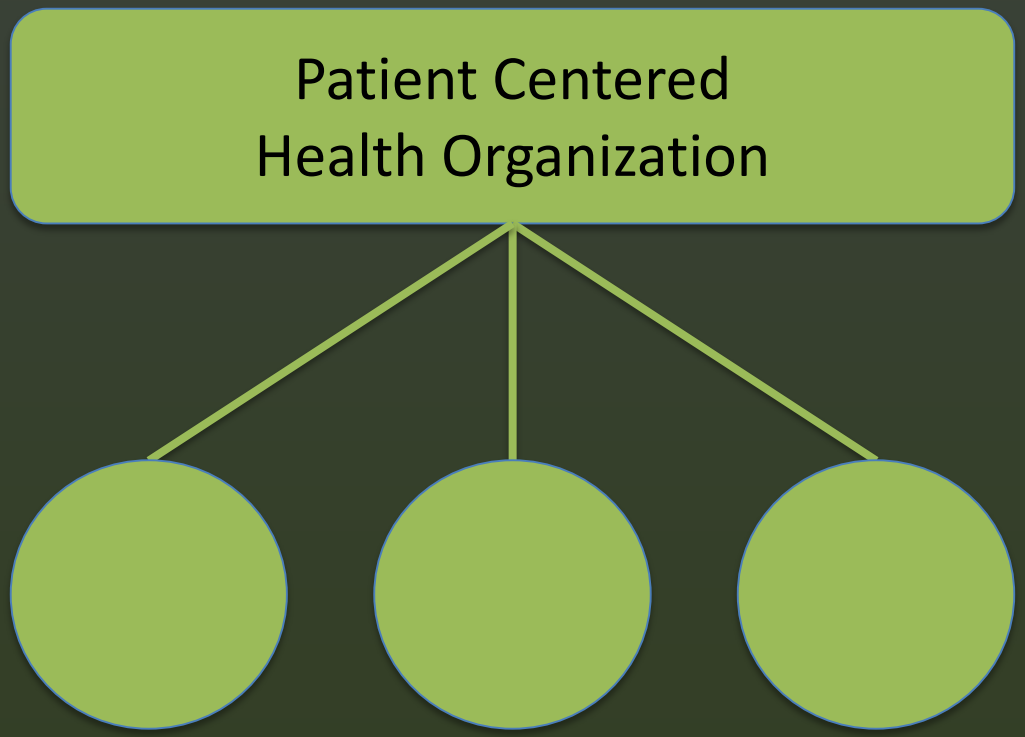


Not all practices have inherent ability to become a PCMH

In partnership with a CCO, a practice can function as a PCMH

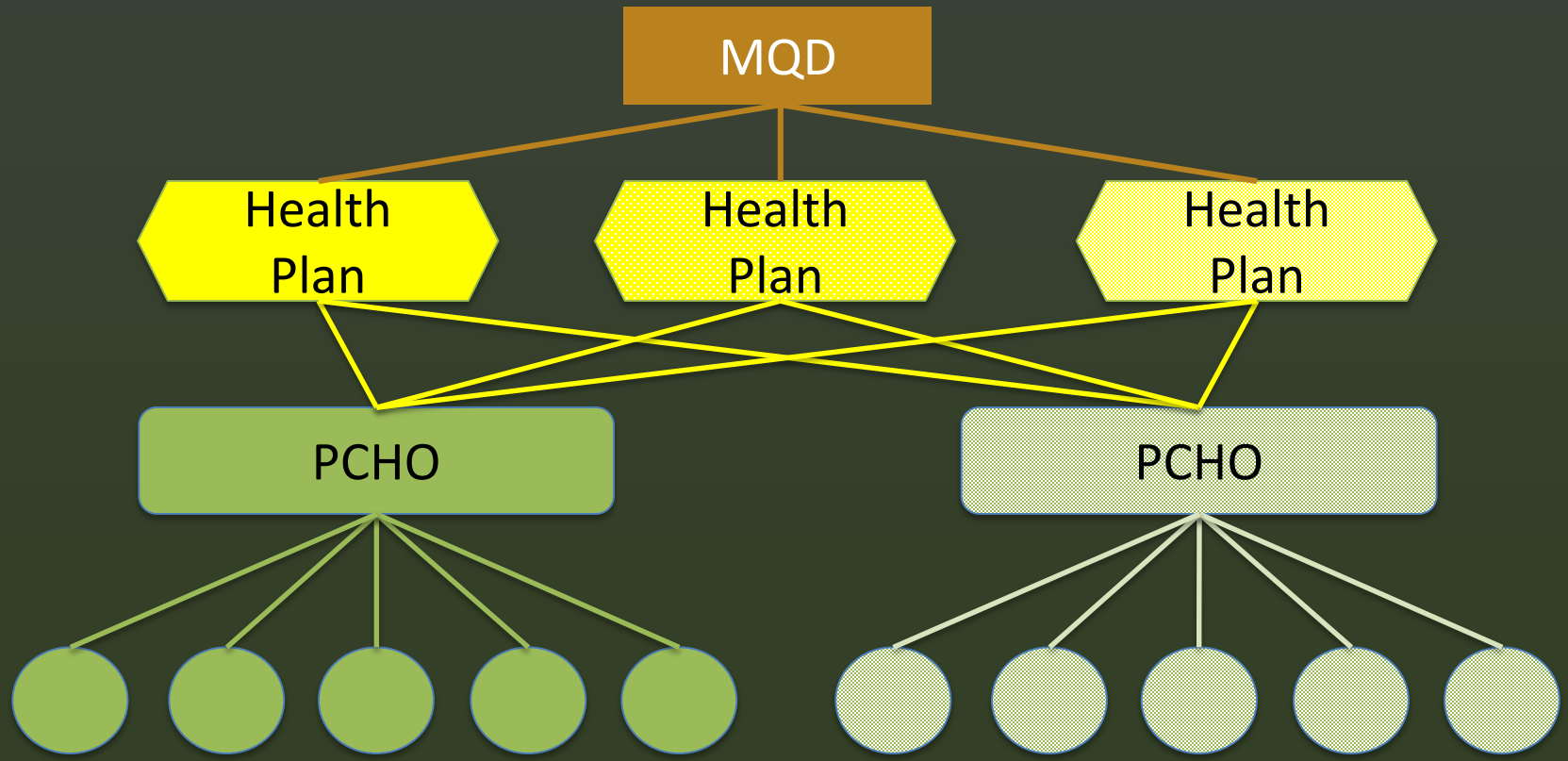


With alignment and shared responsibility, practices and a CCO can become a PCHO

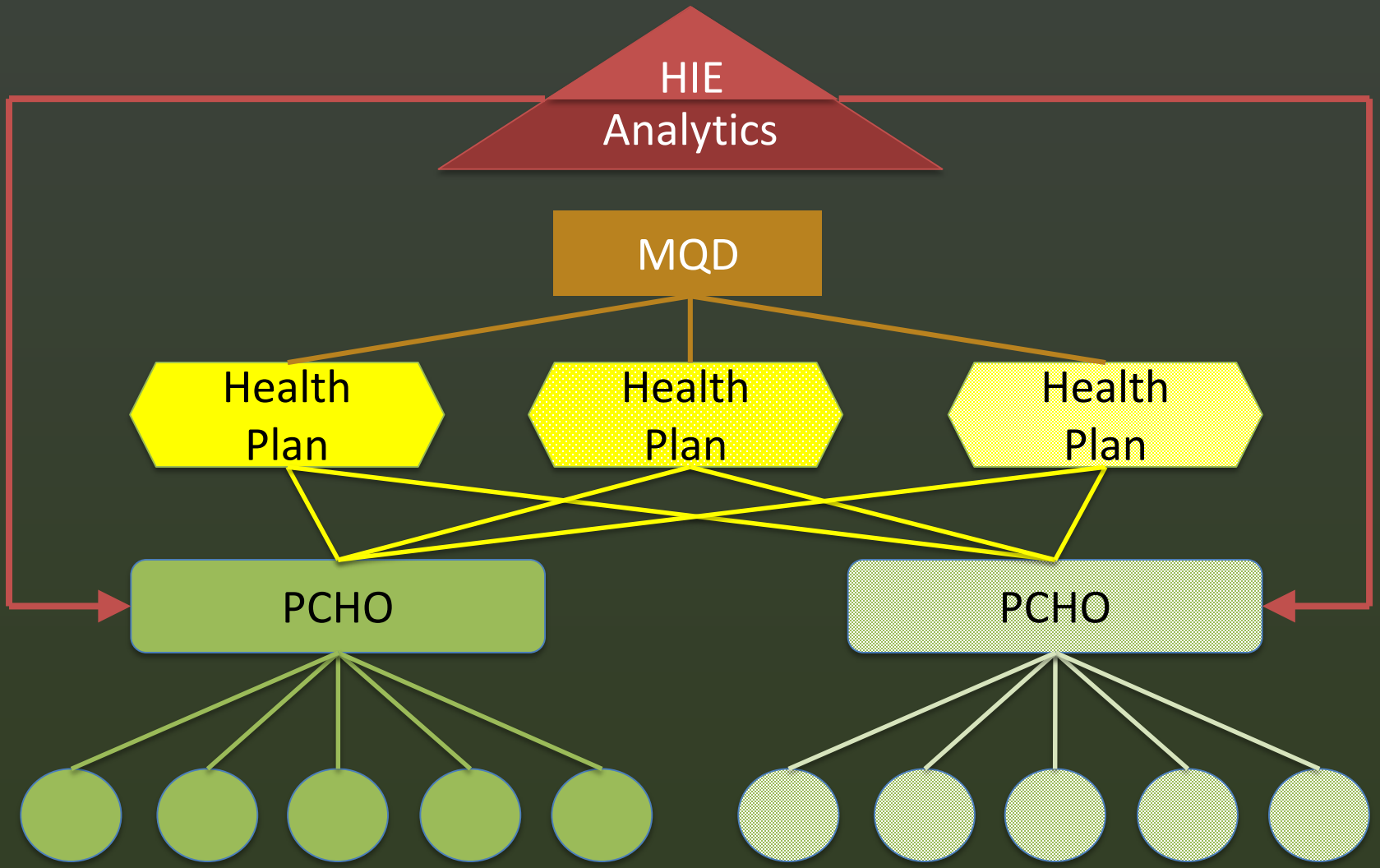


PCMH

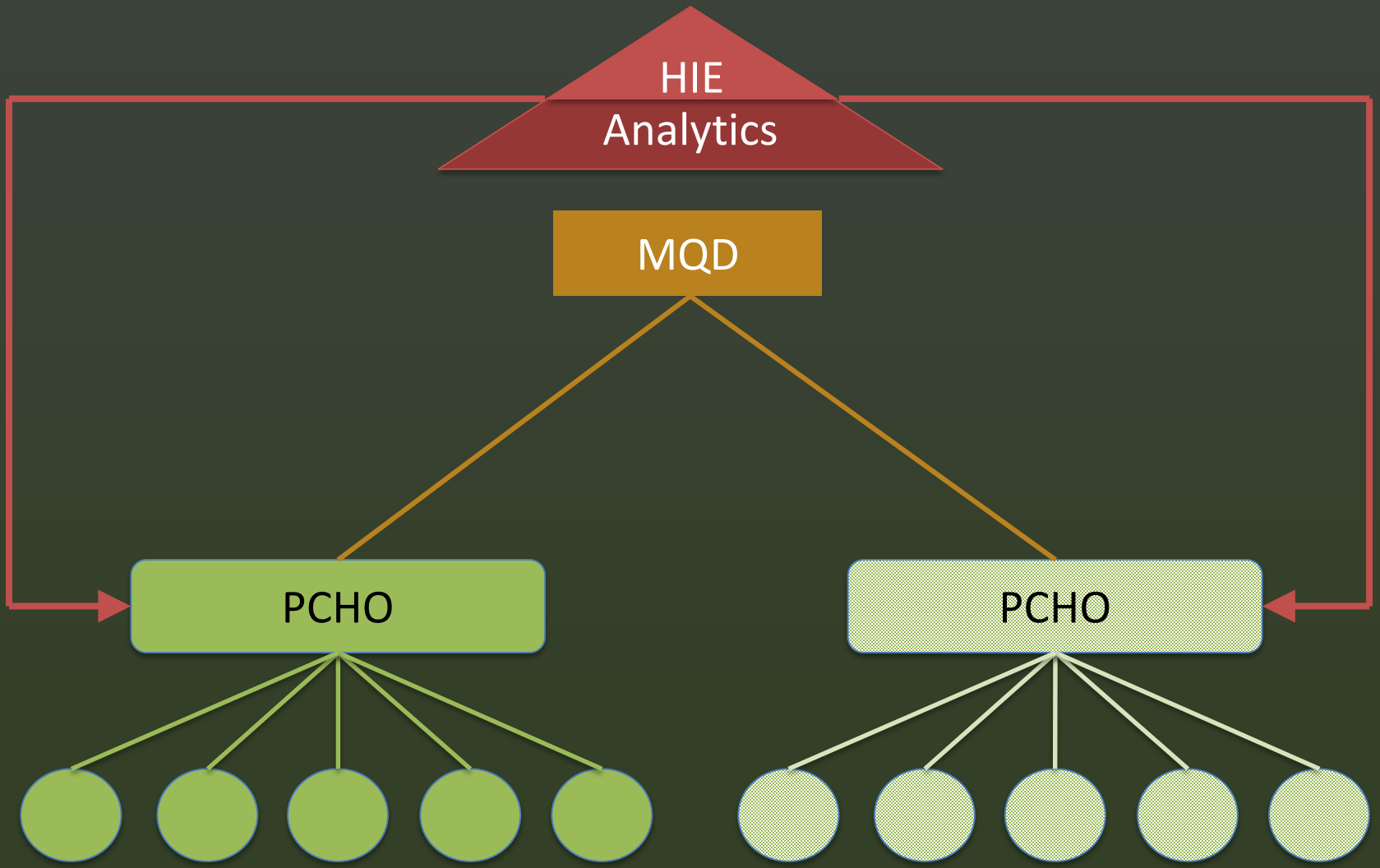
PCHO's can offer economies and efficiencies and enable innovative payment reform



Availability and exchange of data is a key component



In future, MQD could contract with ACOs instead of MCOs



Health Information Technology

- Electronic Health Record incentive program is ongoing (data reported by CMS for September)
  - Medicaid Eligible Professional 272 $5.7 M
  - Medicaid Hospital 2 $3.8M
  - Medicare/Medicaid Hospital 7 $7.1 M

  TOTAL 281 $16.6 M
- MQD is working with the Hawaii Health Information Exchange to leverage available Medicaid funding
  - Received $200 K general fund appropriation last session, receives 90% federal match
  - DHS requesting $150 K/$100 K general fund appropriation, receives 90% federal match

What are the puzzle pieces and how do we put them together?

- Purchasers
  - MQD, EUTF, DOH
  - Hawaii Health Connector
- Providers
  - Hospital systems, FQHCs, small practices
- Hawaii Health Information Exchange
- Funding Opportunities
  - Health home SPA, innovation grant

What other potential opportunities might exist?

- Align State healthcare purchasers as other states have done in a healthcare authority
  - MQD, EUTF cover 40% of residents; health insurance exchange
  - Contractual alignment to advance policy goals and reduce administrative burden on providers
- Develop a client-centric rather than funding-centric approach to service delivery
  - Standardize safety-net
- Invest in public health
  - Best return on investment
  - Value of “health” transformation

Questions?

What lies ahead?

- CMS, the Administration, and the Legislature set the priorities
- Current: QI, SBM, KOLEA, COFAs, adult dental, working disabled, PCP reimbursement, ICD-10
- Upcoming: Autism, health home, Hawaii Healthcare Project SIM, school-based services
- Opportunities: SMI, Dual eligibles, health information technology/exchange