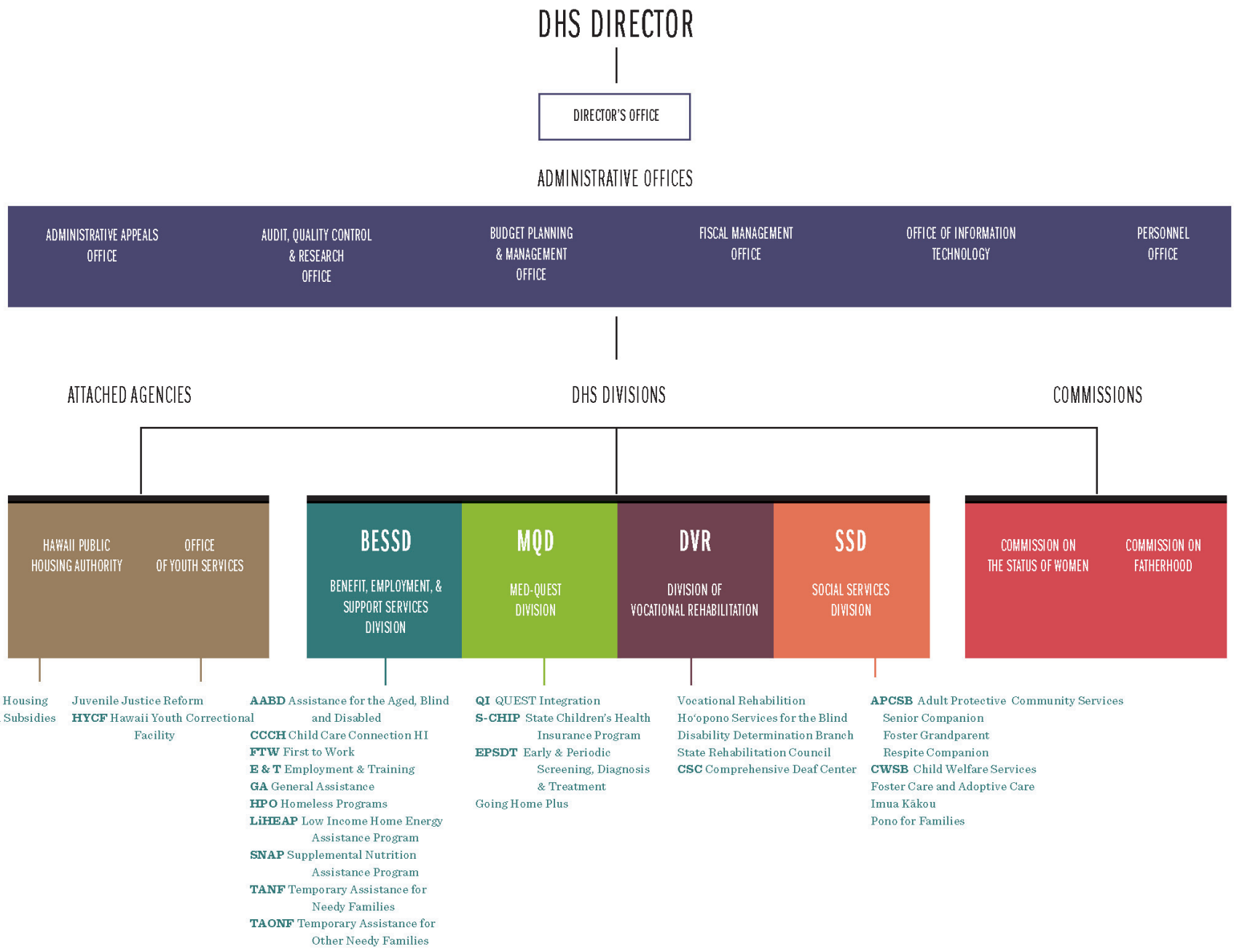
STATE OF HAWAI'I

Department of Human Services

FY 2017 BUDGET PRESENTATION

January 28, 2016


DHS DIRECTOR
DIRECTOR'S OFFICE
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ADMINISTRATIVE APPEALS OFFICE
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OFFICE OF INFORMATION TECHNOLOGY
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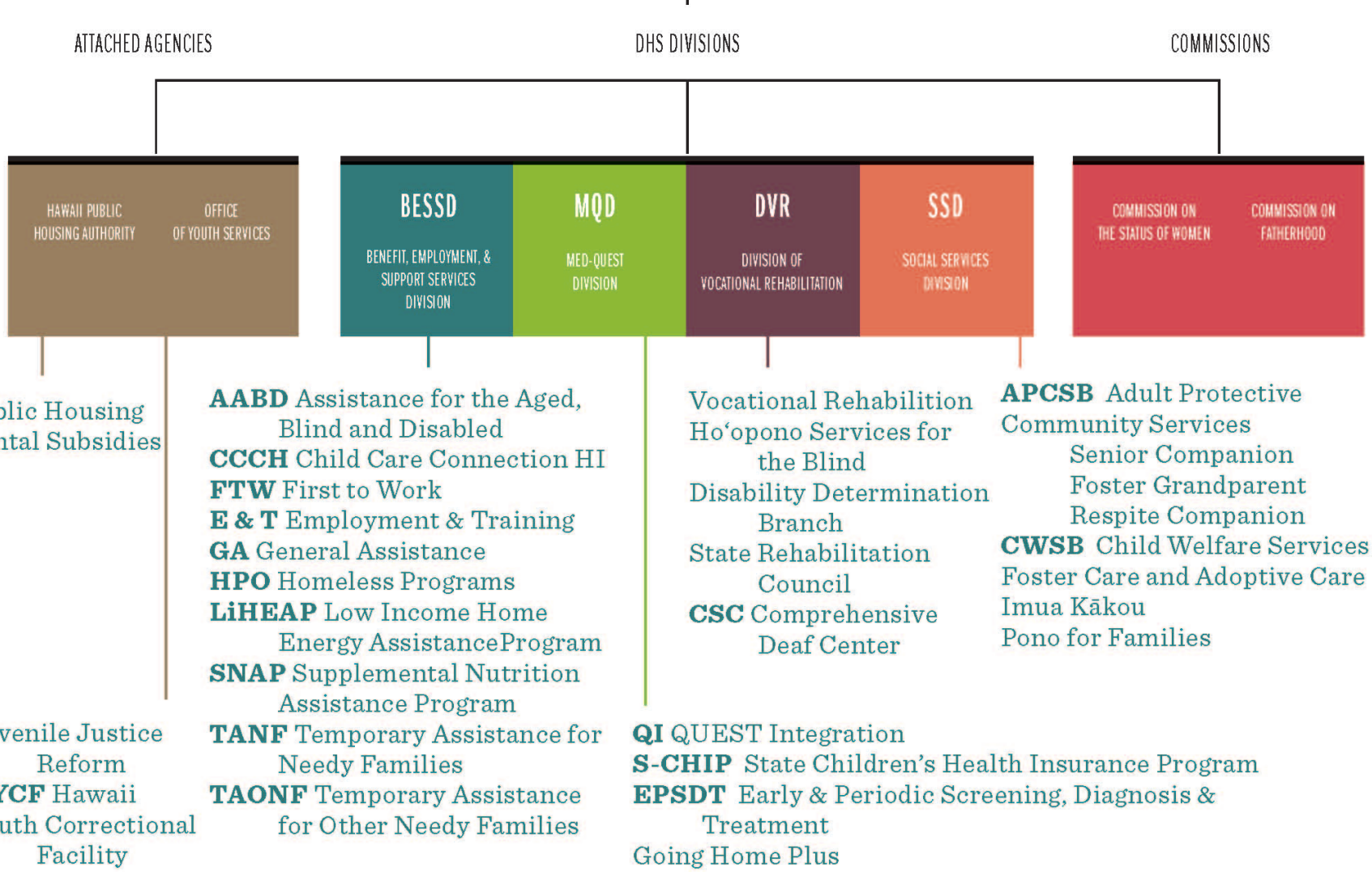
ATTACHED AGENCIES
DHS DIVISIONS
COMMISSIONS
HAWAII PUBLIC HOUSING AUTHORITY
OFFICE OF YOUTH SERVICES
BESSD
BENEFIT, EMPLOYMENT, & SUPPORT SERVICES DIVISION
MQD
MED-QUEST DIVISION
DVR
DIVISION OF VOCATIONAL REHABILITATION
SSD
SOCIAL SERVICES DIVISION
COMMISSION ON THE STATUS OF WOMEN
COMMISSION ON FATHERHOOD
Public Housing
Rental Subsidies
Juvenile Justice Reform
HYCF Hawaii Youth Correctional Facility
AABD Assistance for the Aged, Blind and Disabled
CCCH Child Care Connection HI
FTW First to Work
E & T Employment & Training
GA General Assistance
HPO Homeless Programs
LiHEAP Low Income Home Energy Assistance Program
SNAP Supplemental Nutrition Assistance Program
TANF Temporary Assistance for Needy Families
TAONF Temporary Assistance for Other Needy Families
QI QUEST Integration
S-CHIP State Children's Health Insurance Program
EPSDT Early & Periodic Screening, Diagnosis & Treatment
Going Home Plus
Vocational Rehabilition
Ho'opono Services for the Blind
Disability Determination Branch
State Rehabilitation Council
CSC Comprehensive Deaf Center
APCSB Adult Protective Community Services
Senior Companion
Foster Grandparent
Respite Companion
CWSB Child Welfare Services
Foster Care and Adoptive Care
Imua Kākou
Pono for Families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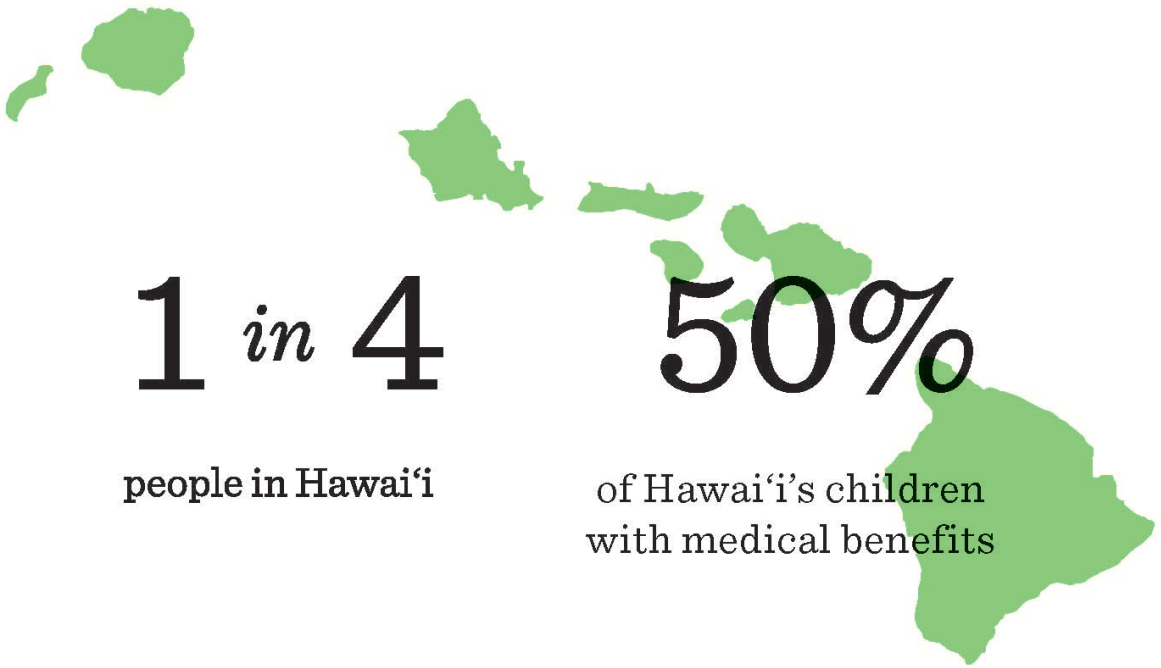
DHS

DEPARTMENT OF HUMAN SERVICES

serves



1 *in* 4

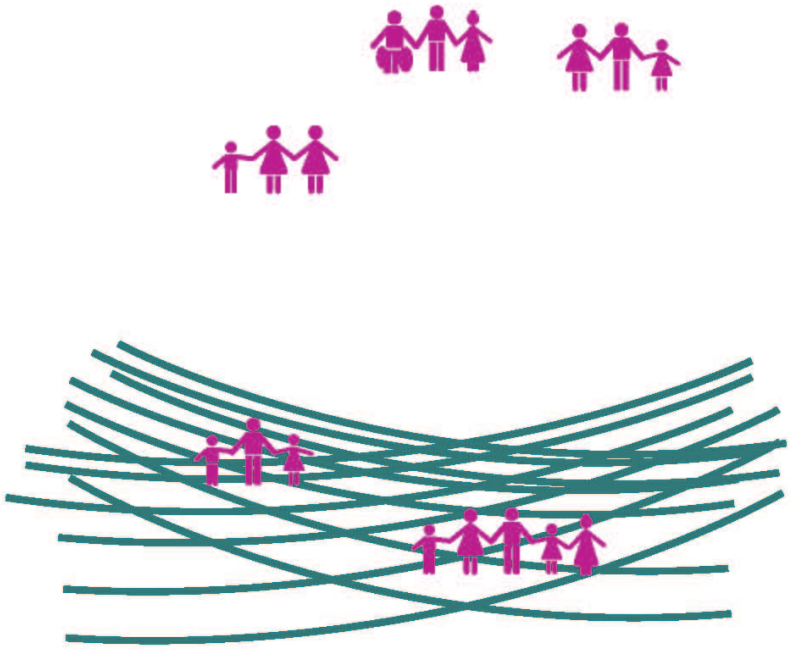
people in Hawai‘i

50%

of Hawai‘i’s children
with medical benefits

DHS

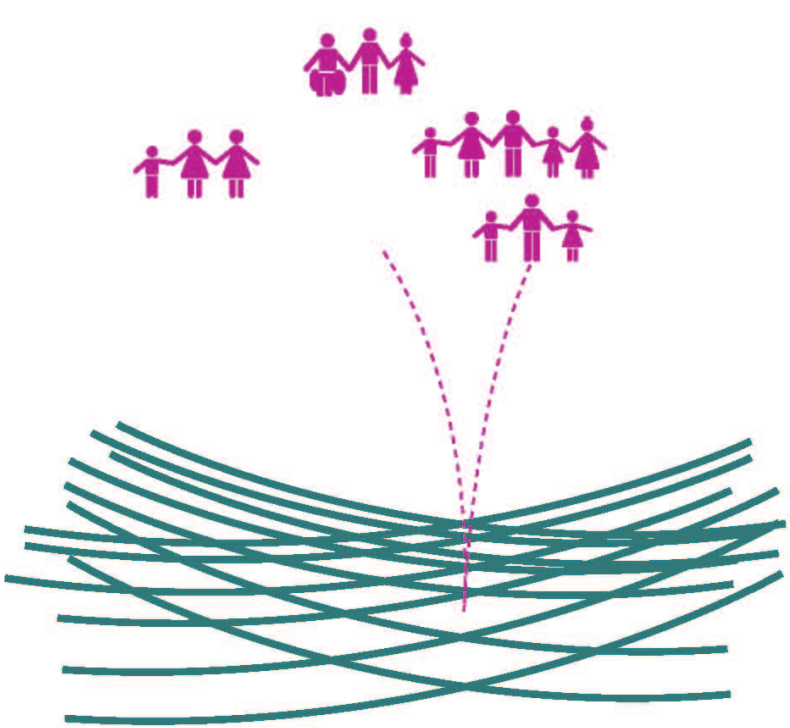
DEPARTMENT OF HUMAN SERVICES

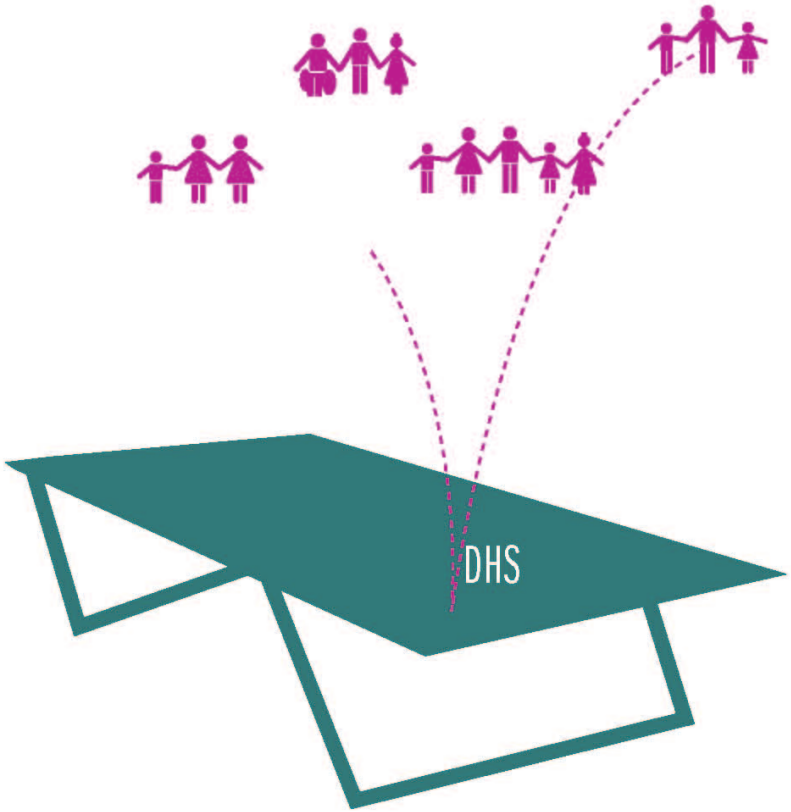


not just a safety net,

DHS

DEPARTMENT OF HUMAN SERVICES



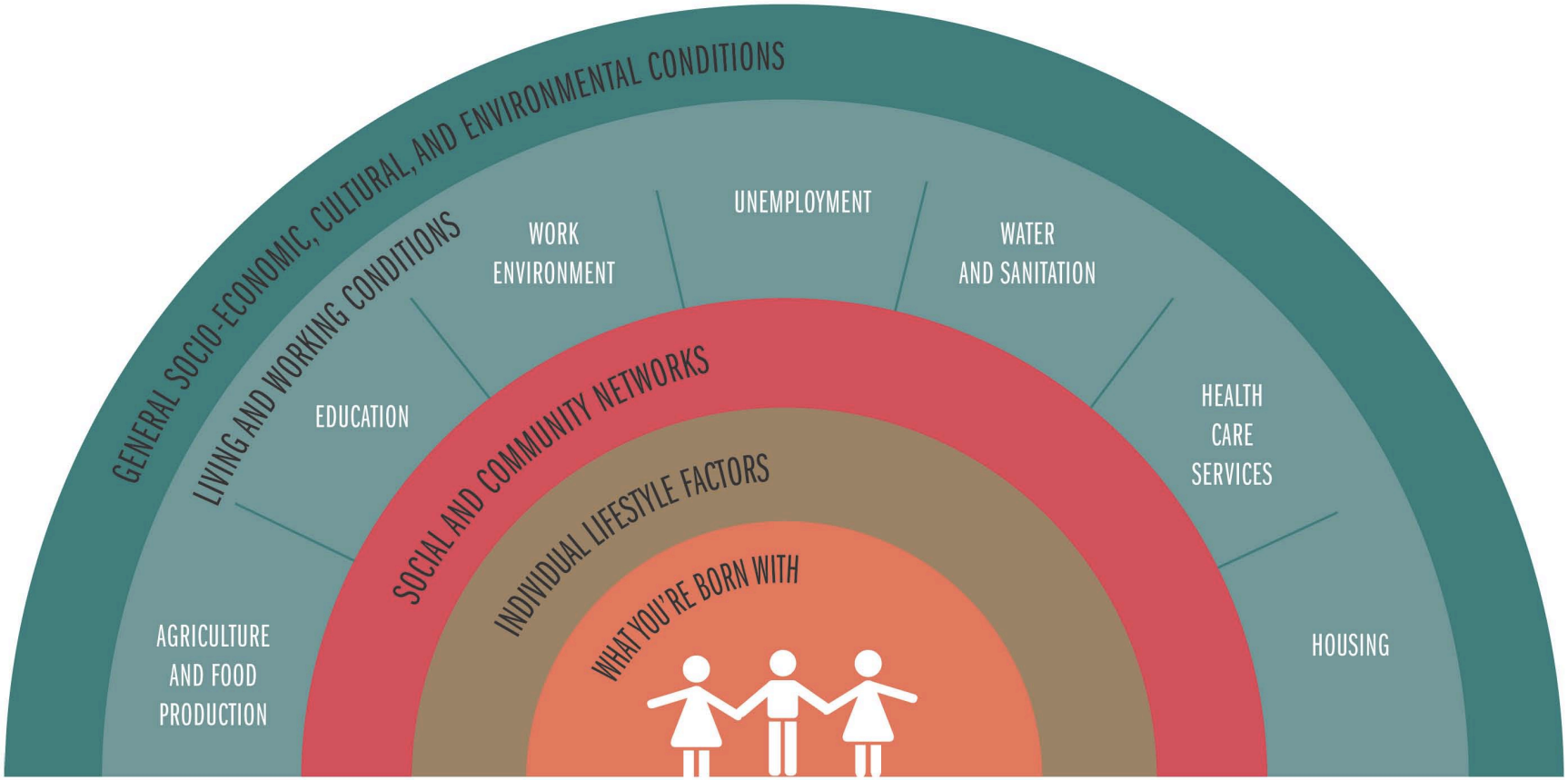


a trampoline

THE SOCIAL DETERMINANTS OF HEALTH

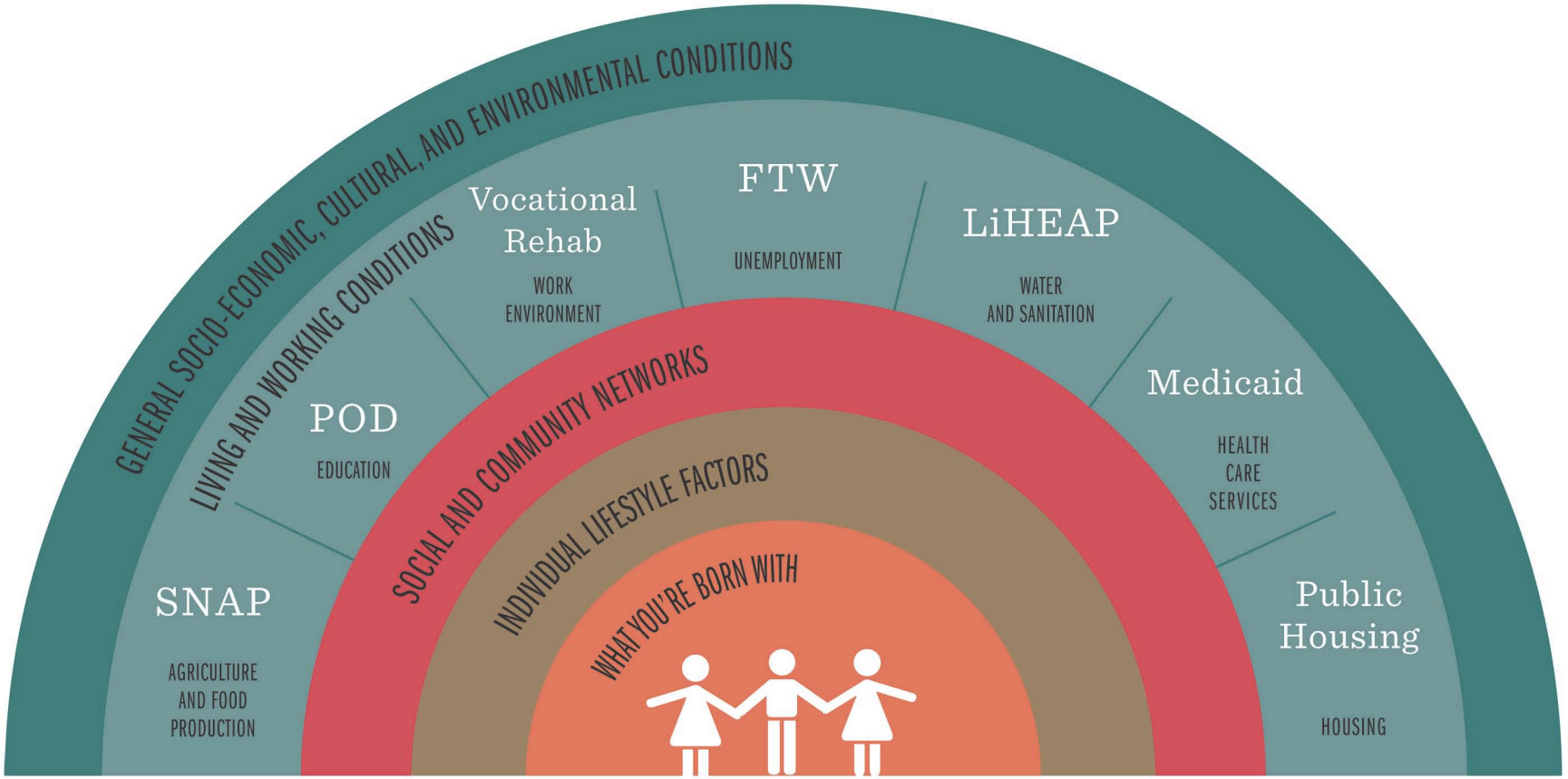
for

a Healthy Community



Source: Dahlgren and Whitehead, 1991

DHS PROGRAMS
are integral
to a Healthy Hawai‘i



Source: Dahlgren and Whitehead, 1991

Poverty and health outcomes

Physical Health Indicators, by Income Group

Annual income

	<$24K (low income)	$24K-<$90K (middle class)	$90K+ (high income)	Gap, low vs. high income (pct. pts.)
% Obese	32.0	27.9	21.7	10.3
% Diabetes	16.1	10.1	6.7	9.4
% High blood pressure	36.4	29.0	23.6	12.8
% High cholesterol	29.3	26.4	25.3	4.0
% Heart attack	7.2	3.5	2.2	4.9
% Asthma	15.9	10.5	9.2	6.7
% Cancer	7.7	6.9	6.0	1.7
% Diagnosed with depression	29.0	15.2	10.2	18.7
% Headache	18.7	10.2	7.5	11.1
% Flu	2.7	1.2	1.0	1.8
% Cold	7.0	4.7	4.3	2.7

Jan.1-Sept. 28, 2010

Gallup-Healthways Well-Being Index

http://www.gallup.com/poll/143696/health-disparities-across-incomes-wide-ranging.aspx

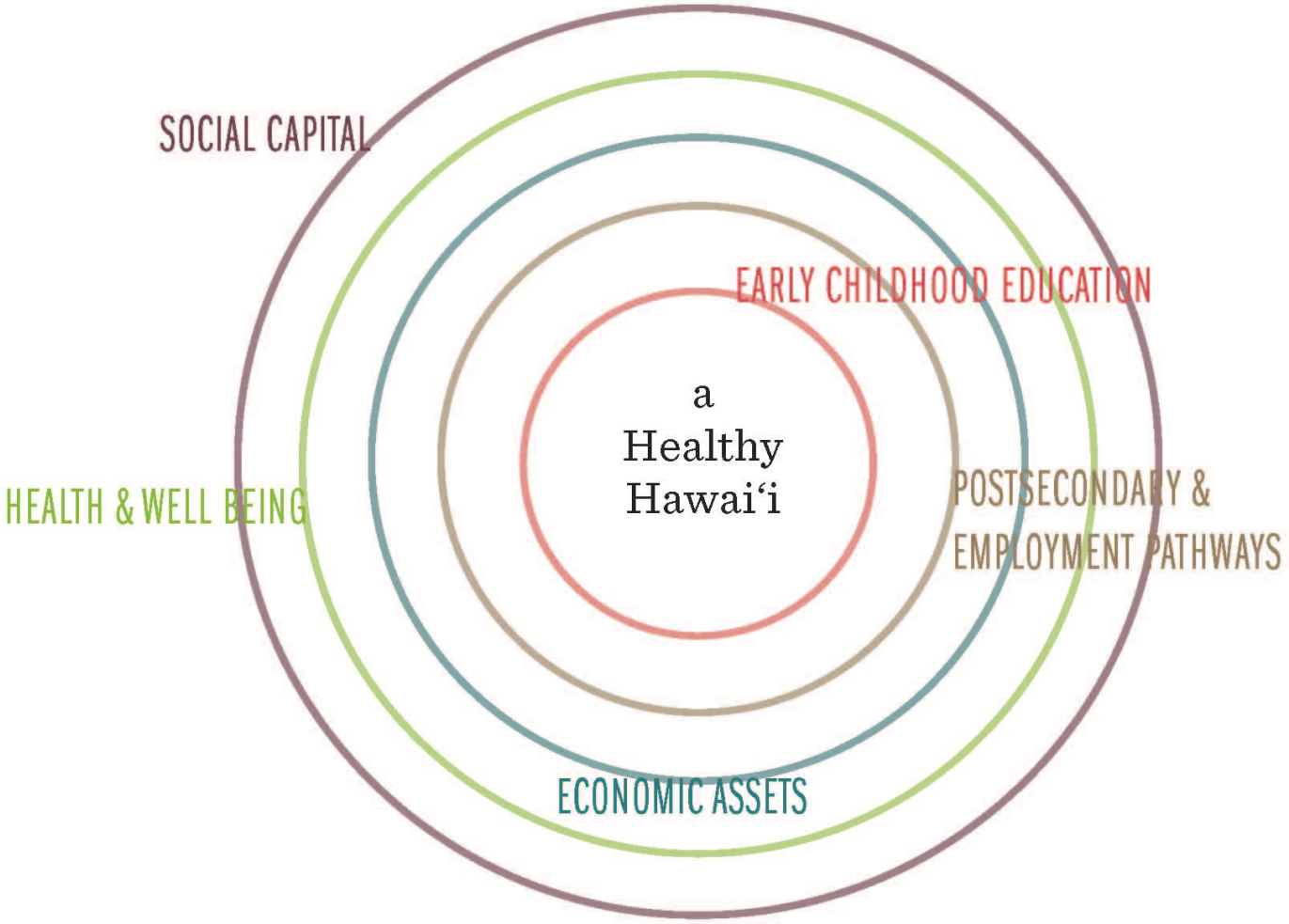
How

do we translate this into

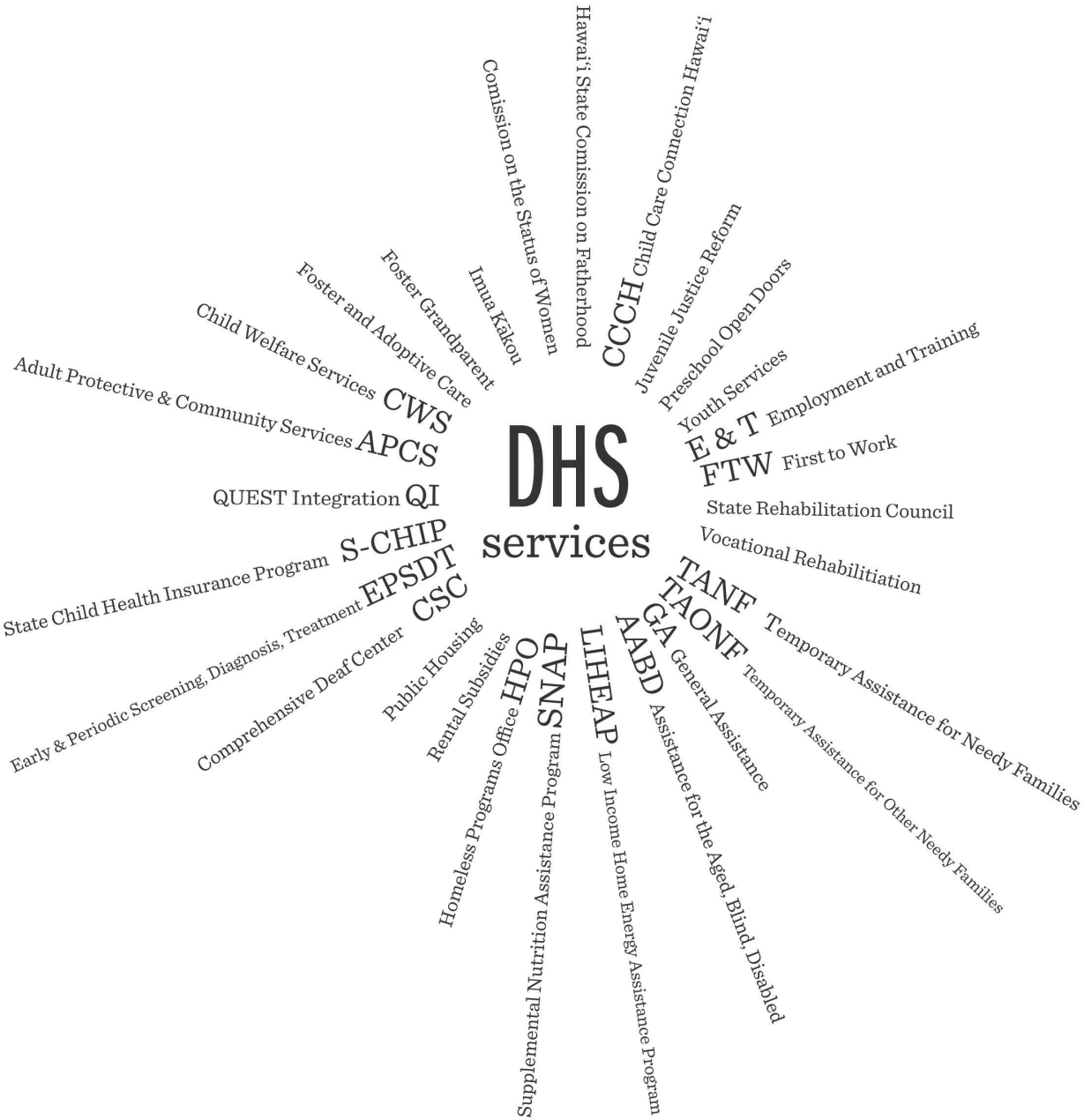
ACTION ?

We must *transform*

programs and components into systems



Source: Ascend at the Aspen Institute, 2Gen Approach


DHS
services
Hawai'i State Comission on Fatherhood
CCCH Child Care Connection Hawai'i
Comission on the Status of Women
Juvenile Justice Reform
Imua Kākou
Preschool Open Doors
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a Healthy Hawai'i
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Hawai'i State Comission on Fatherhood
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Imua Kākou
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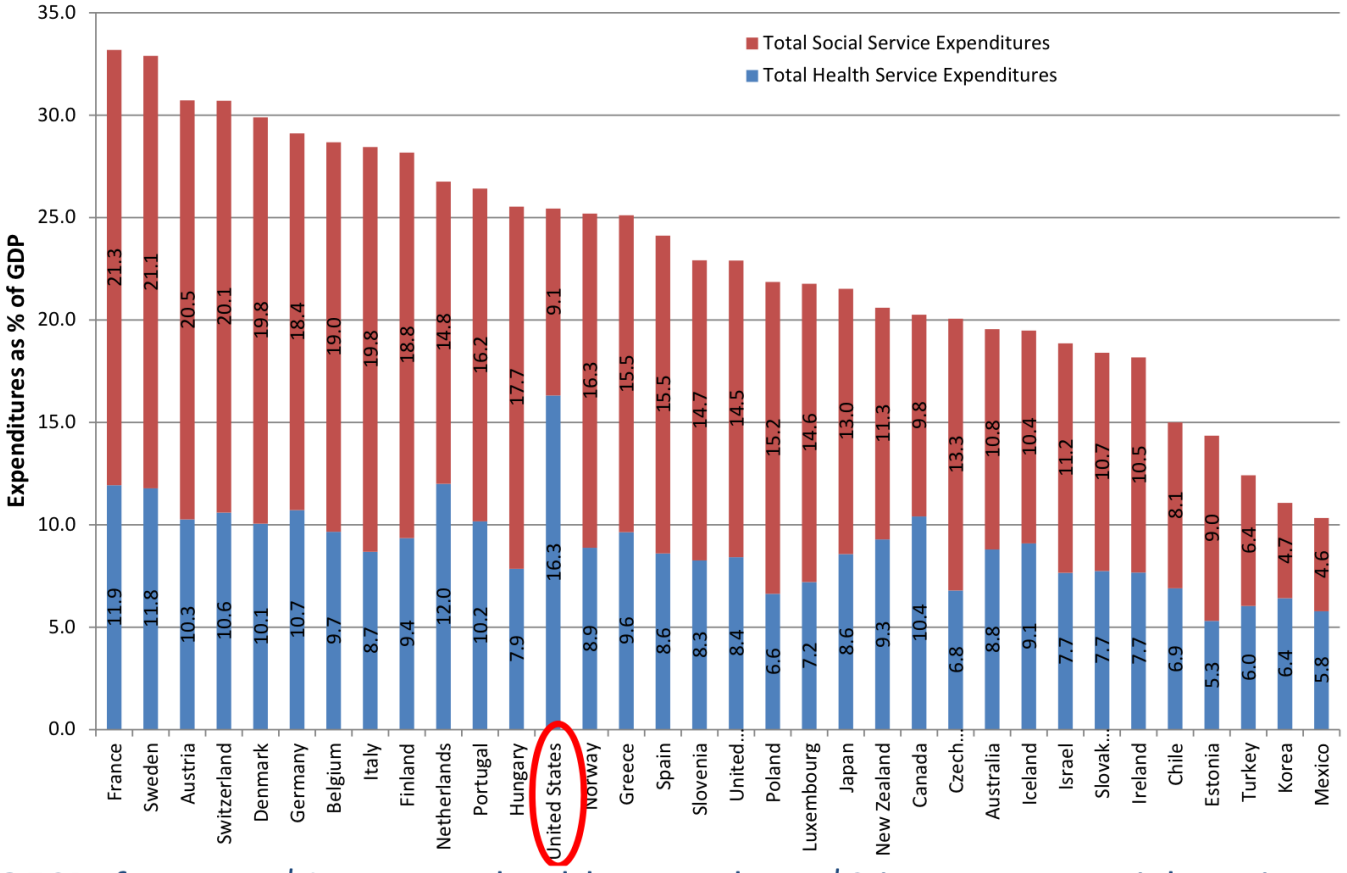
Investment in social services



In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services

Bradley and Taylor, The U.S Health Care Paradox: How Spending More is Getting Us Less, http://academyhealth.org/files/2013/sunday/bradley.pdf

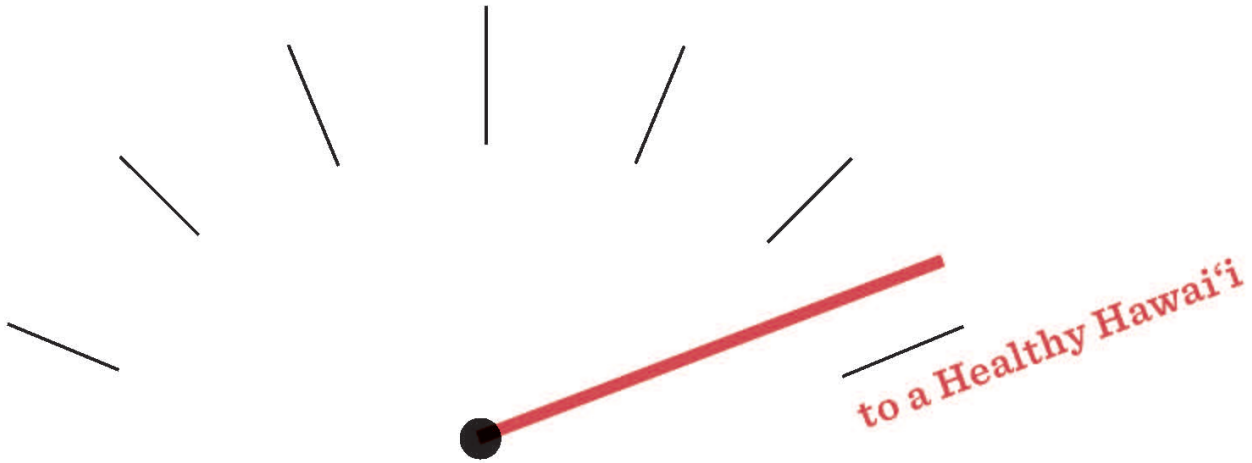
Findings

Significant association of the following health outcomes with the ratio of social to health spending:

- Life expectancy
- Premature death (increased potential life years lost)
- Low birth weight
- Infant mortality

Bradley, et al. (2011), BMJ Quality & Safety

How DHS can
move the needle



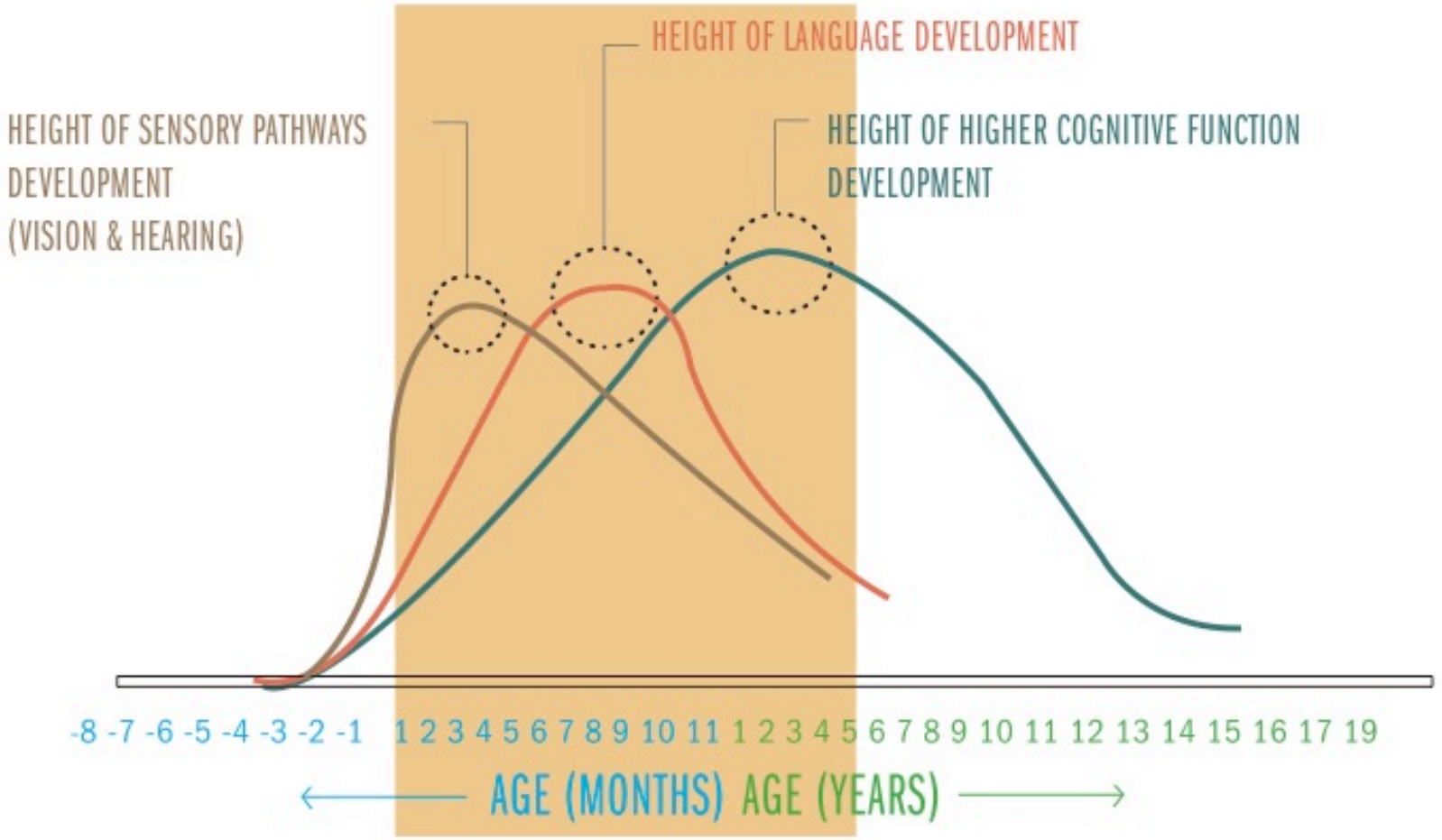
Our greatest return on investment

are *children,*

ages 0 –5.

CRITICAL BRAIN DEVELOPMENT

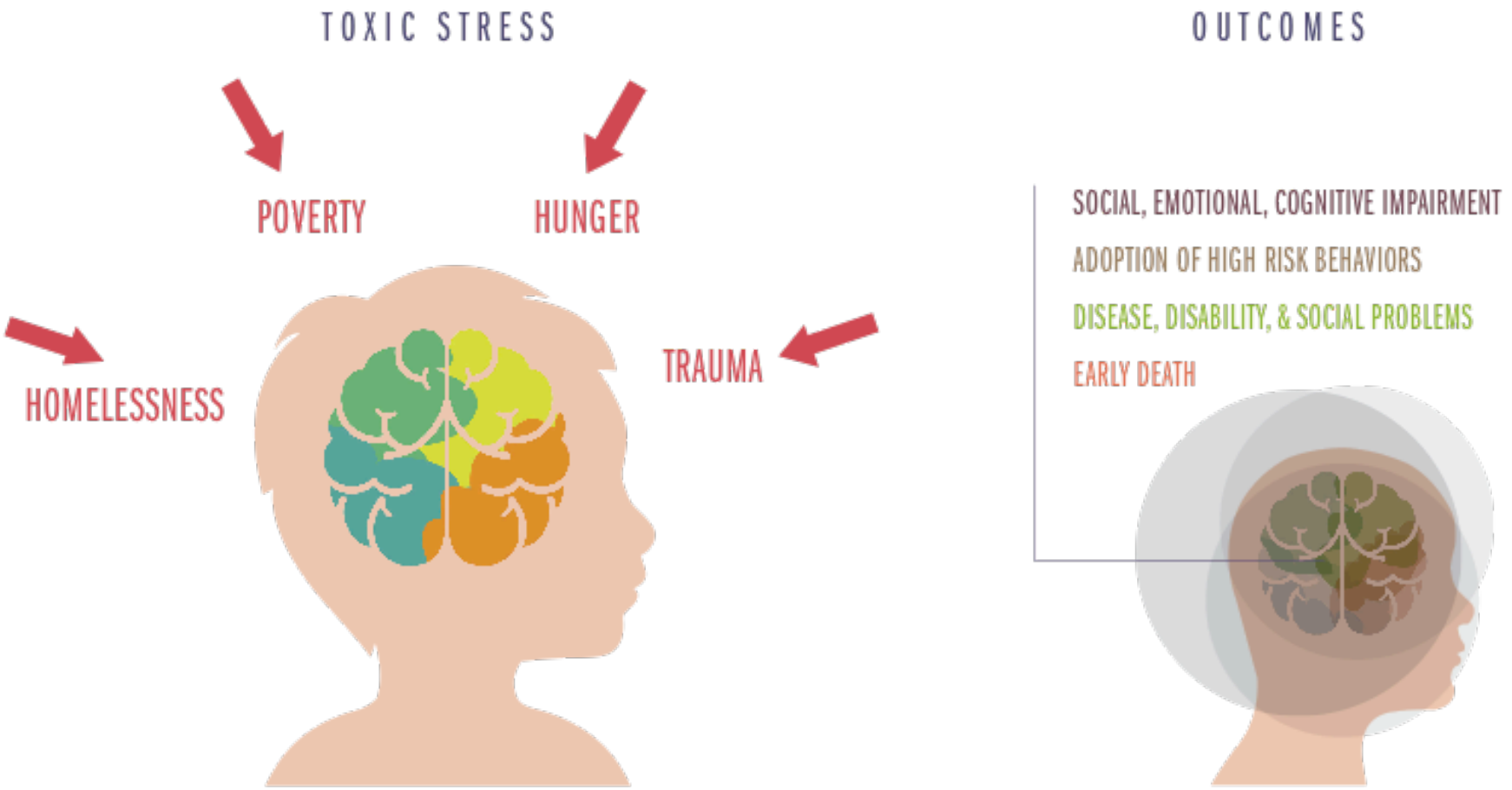
occurs during the first 5 years



Source: Harvard University, Center for the Developing Child

ACEs (ADVERSE CHILDHOOD EXPERIENCES)

affect long term health outcomes



Source: Centers for Disease Control, Violence Prevention

Our greatest return on investment

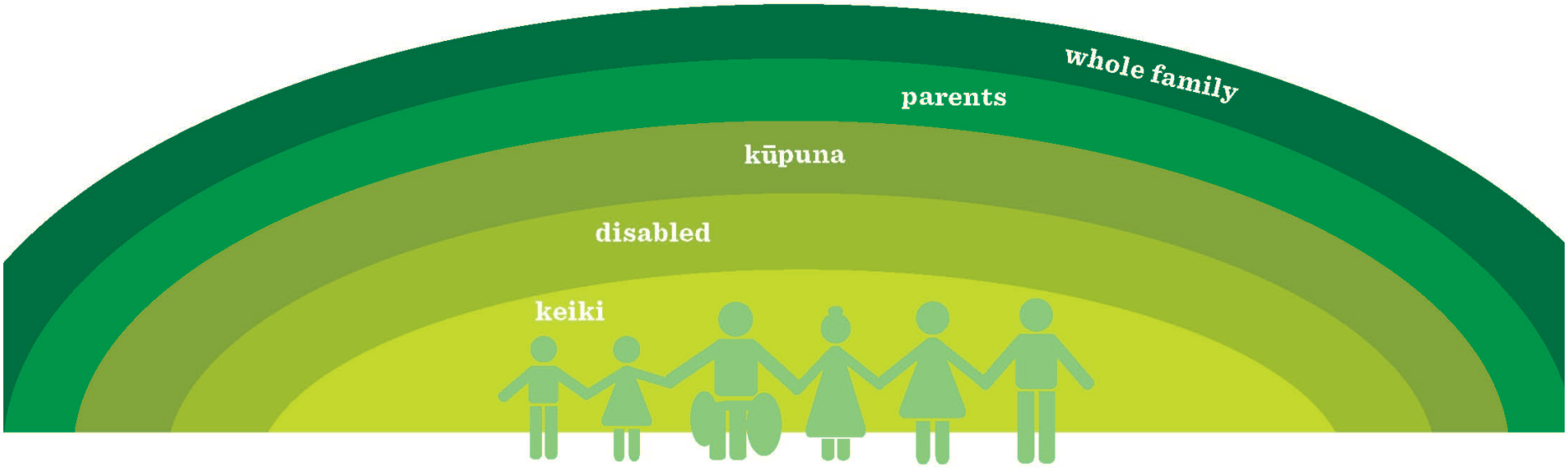
are *children,*

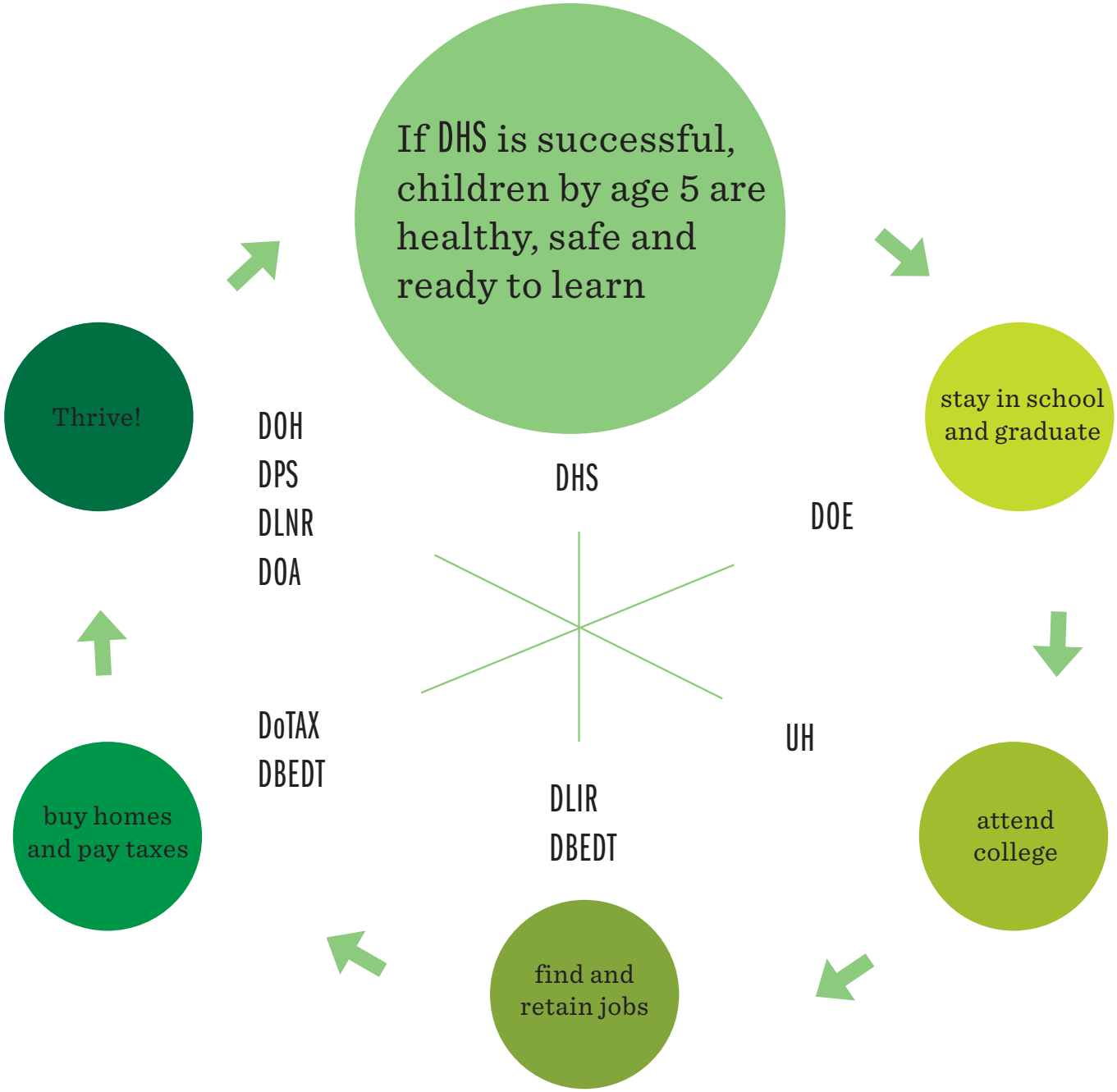
ages 0 –5.

When we support **children,** the whole family benefits
When we support **families**, children thrive

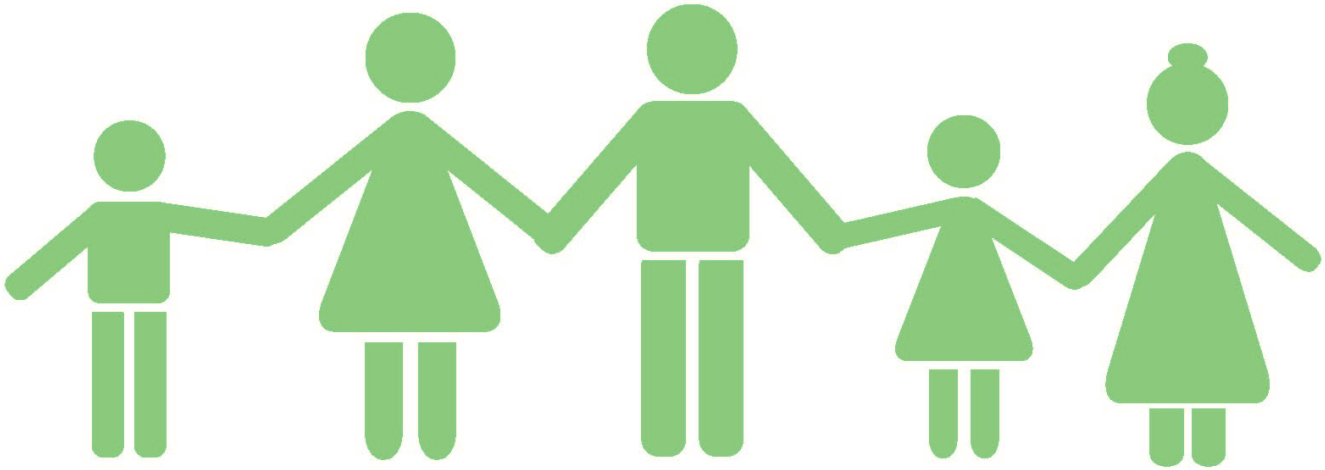
Hawai‘i multi-generational approach:

‘Ohana Nui




If DHS is successful, children by age 5 are healthy, safe and ready to learn
DHS
stay in school and graduate
DOE
attend college
UH
find and retain jobs
DLIR
DBEDT
buy homes and pay taxes
DoTAX
DBEDT
Thrive!
DOH
DPS
DLNR
DOA

Healthy Families = A Healthy Hawai‘i



DHS Budget (FY17)

Areas of focus:

- **Invest in children** and families
- Improve **health** and **safety**
- **Increase** departmental **capacity** and **efficiencies**
- **Improve** systems

Invest in children and families

- Preschool Open Doors - $6M (HMS 305)
- Autism therapy - $10.6M (HMS 401)
- Kaka‘ako Shelter - $900K (HMS 224)
- R.E.A.C.H. - $250K (HMS 501)
- College stipends for former foster youth - $0 (HMS 301)
  - HB2349
  - SB2878

Improve health and safety

- Restore Adult Dental - $4.8M (HMS 401)
  - Federal match: $7.66M
- Ticket to Work - $293,405 (HMS 401)
  - Federal match: $344,155
- Solvadi treatment - $8M (HMS 224)
  - Federal match: $9.38M
- Expand Premium Assistance Program – $900K (HMS 401)

Improve health and safety

- Homeless outreach - $2M (HMS 224)
- Housing First - $3M (HMS 224)
- Rapid re-housing - $2M (HMS 224)

Increase capacity & efficiency

- Transfer 16 vacant positions - $0 (HMS 301)
- Restore MSW program - $331K (HMS 301)
  - Federal match: $110K
- Add appeals position - $25K (HMS 904)
  - Federal match: $12K
- Restore second deputy and add three positions - $371,364 (HMS 904)
  - HB 2348
  - SB 2877

Increase capacity & efficiency

- Invest in MQD staff - $375K (HMS 902)
  - Federal match: $375K
- DHS Enterprise System M&O - $5.9M (HMS 902)
  - Federal match: $17.2M
- DD&I (takeover) - $500K (HMS 902)
  - Federal match: $4.5M

Improve systems

- Health IT DD&I - $600K (HMS 902)
  - Federal match: $5.4M
- Health Information Exchange - $100K (HMS 902)
  - Federal match: $900K
- Funding for GOV's Special Homelessness Project - $235K (HMS 904)
- Homeless outreach, Housing First, Rapid Re-housing (HMS 224)

When we support **children,** the whole family benefits
When we support **families**, children thrive

Hawai‘i multi-generational approach:

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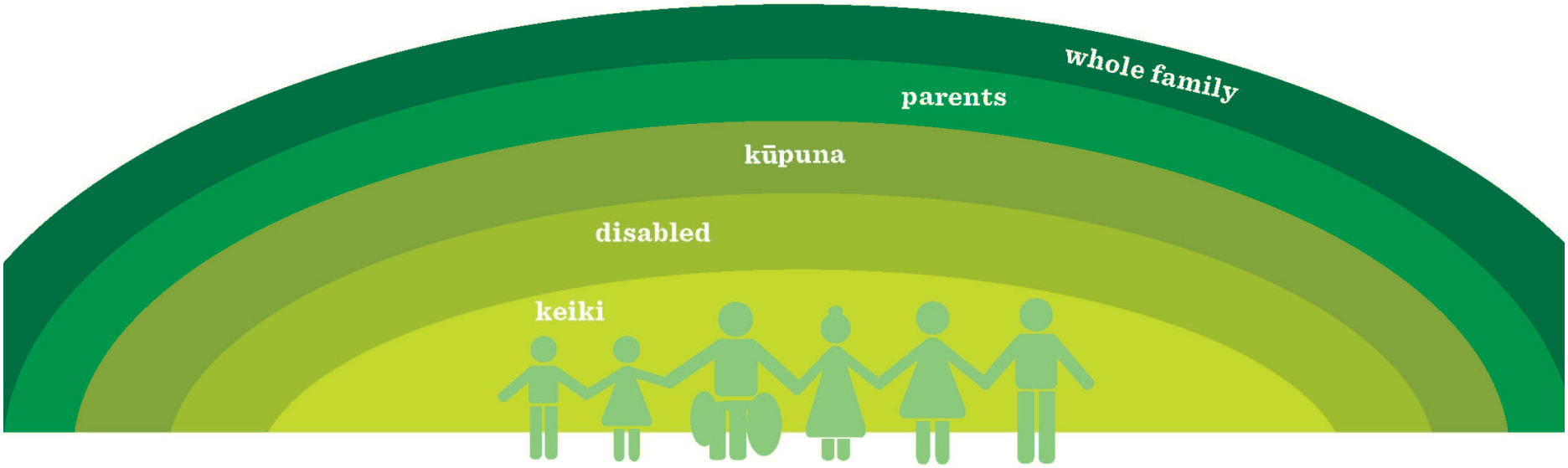

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

January 27, 2016

TO: The Honorable Senator Suzanne Chun Oakland, Chair
Senate Committee on Human Services

The Honorable Representative Dee Morikawa, Chair
House Committee on Human Services

FROM: Rachael Wong, DrPH, Director

SUBJECT: Informational Briefing

Hearing: Thursday, January 28, 2016, 1:30 p.m.
Conference Room 016, State Capitol

Attached for your information and review is the Department of Human Services' December 22, 2015 response to the State Auditor's draft no. 4, *Audit of the Department of Human Services' KOLEA System*.

Thank you for the opportunity to provide information on this issue.

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

The Honorable Jan K. Yamane
Acting State Auditor
Office of the Auditor
465 S. King St., Room 500
Honolulu, HI 96813-2917

December 22, 2015

Dear Ms. Yamane,

Thank you for your letter dated December 14, 2015 regarding the draft report no. 4, *Audit of the Department of Human Services' KOLEA System*. We reviewed the report and appreciate several of the State Auditor recommendations but disagree with the two primary conclusions made in the report. The "findings" that the KOLEA application does not meet the Affordable Care Act (ACA) goals is wholly incorrect and may be based on a limited understanding of the complex federal statute and requirements for the state's Medicaid program.

The Centers for Medicare & Medicaid Services (CMS), the federal oversight agency for the state Medicaid program, confirmed its confidence in the KOLEA application's accurate and timely determination of Medicaid eligibility. In fact, Hawai'i is one of only two states in the country that has successfully implemented all Medicaid programs in its eligibility system, so there is a disconnect between what CMS has determined and the conclusions in the report.

There is a great deal to clarify and address in the draft audit report, so in this letter we will: 1) address Auditor recommendations, 2) provide clarification of terminology, audit objectives, and indicators, and 3) respond to the audit context, process, and findings.

Before doing so, we would like to make a few notes. For one, the KOLEA app has improved significantly since its October 1, 2013 launch. We also value the feedback on KOLEA and from our eligibility workers. We appreciate the majority of the Auditor's recommendations and recognition that DHS must move forward with its integrated DHS Enterprise System. As intended, we will use the final audit report as a tool for continued improvement.

I. Auditor recommendations

We agree with the following recommendations (paraphrased for length) and note the actions already taken or planned to address each item below:

- 1a: Hold future DHS IT projects to "rigorous...process standards."

  ACTION: This year, the DHS Enterprise System governance model was vetted and approved. It includes a formal Project Management Office (PMO), Executive Steering Committee (members include the Director, Deputy Director, Division Administrators, and the State CIO), Operations Committee, and staffing for the PMO.

- 1bi: Address Medicaid income verification issues by finalizing the MOU with the Department of Labor and Industrial Relations (DLIR).

  ACTIONS:

  1. DLIR is currently building a database that will be a copy of its production data and will be accessible by DHS and other State departments to perform data matches without impacting its system's operational performance. DLIR will notify DHS when the build is completed.
  2. DHS and DLIR are working together on an MOU which is expected to be finalized and executed in 2016.

- 2a: Clearly-define KOLEA project responsibilities.

  ACTIONS:

  1. MQD has already implemented clear functional responsibilities relative to KOLEA and will continue to monitor, evaluate and adjust as needed.
  2. The DHS Director and Med-QUEST Administrator have been actively working with the vendor and users to identify areas that can be improved. The current process includes reviewing reported problems, prioritizing changes and performing scheduled releases.

- 2b: Establish goals, objectives, performance targets, and performance measures for the Medicaid eligibility and processes.

  ACTION: DHS and MQD appreciate the Auditor's recommendations and concur that it is important to measure the processes so that improvements can be made when needed. Therefore, DHS and MQD included business process re-engineering in its FY17 budget request to engage all staff in the transformation of Medicaid business processes using KOLEA. Analyzing and potentially expanding the performance metrics from what currently collected would be part of that process. Should modifications be needed for KOLEA to capture additional performance metrics, that will be taken into consideration and prioritized with other possible improvements.

- 2c: Ensure Administrative Rules, Policies and Procedures for eligibility and enrollment align with ACA and align with Eligibilty Branch

  ACTION: A review and any necessary revisions of the eligibility Hawai'i Administrative Rules (HARs) have been underway, being completed, and they are always reviewed by the Attorney General's office to ensure their alignment with relevant federal and state statutes. When appropriate, the Verfication Plan will be updated. However, income verification, per the specific audit recommendation, may not be needed, and thus, the income verification plan may not be needed.

  As noted in the prior and next Action item, the business process redesign would address involvement of the Eligibility Branch in the eligility process redesign. Training is also an essential component.

- 2d: Work with the vendor to address functionality and usability issues

  ACTION: The DHS Director and Med-QUEST Administrator have been actively working with PCG, the contracted IV&V vendor, since September 2015 to monitor and provide increased oversight of KPMG, the vendor contracted to build the KOLEA app. We have requested identifying and remedying issues, installing relevant system patches, and delivering documentation of practices that will allow for a smooth turnover to another vendor (should that occur).

- 2e: Ensure the MQD Training office collaboratively provides appropriate training

  ACTIONS:

  1. We recognize that training is an important component of any new process, and that many eligibility workers felt they did not receive adequate training. DHS and MQD Administration also recognize that investment in staff is important and therefore included business process re-engineering in its FY17 budget request to engage all staff in the transformation of Medicaid business processes using KOLEA. Training is an essential component to the business process re-design.
  2. One ongoing deficit is that the positions in the Training Office are currently vacant and have been difficult to fill. MQD Administration is examining the positions and discussing ways to promote the filling of them.

There is one (1) Auditor recommendation with which DHS disagrees:

- 1bii: Establish and interface with the Internal Revenue Service (IRS) to check unearned income.

  REASONS:

  1. There is no ACA requirement that all verifications be conducted electronically. The Act requires that states verify financial and non-financial information on an individual's application using a modern, data-driven approach that minimizes

paper documentation from the individual.[1] Each state was required to submit a "verification plan" outlining its approach to this new requirement. Hawai'i (DHS) did so, and CMS approved its Verification Plan in November 2013.

2. Verification with IRS is not required, and DHS chose not to interface with the IRS 1040 data through the Federal Data Services Hub (FDSH) because the data would be more than one year old and more current information is preferred. This was in the CMS-approved Verification Plan.
3. While an interface with the IRS could be established for unearned income (e.g., interest, dividends), it would also be old data and therefore of limited use and value. Additionally, most applicants do not report substantial income from these sources. The Department therefore, and as allowed by federal regulation, opted to not establish an interface with the IRS as it would not be cost effective.

II. Clarification of terminology, audit objectives, and indicators

We would like to use this opportunity to provide a few important clarifications and respectfully request that correct terminology be included in the final audit report:

1. **Terminology**: At the time the audit was requested, the Kauhale On-Line Eligibility Assistance (KOLEA) system referred to the entire system that included the underlying *enterprise system* (hardware/software) and the Medicaid eligibility *application* that provides the functionalities used by the workers to make an eligibility determination. Thus, there was understandable confusion when the name of the platform was changed to the "DHS Enterprise System" to be consistent with the language used to describe the integrated human services systems in the OMB (Office of Management & Budget) Circular A-87. We respectfully request that the correct terminology be used in the audit report to accurately describe and reference the department's enterprise system and the Medicaid eligibility app.
    a. The **"DHS Enterprise System"** represents the primary component of the U.S. Department of Health & Human Services (DHHS) and the U.S. Department of Agriculture's (USDA) "shared vision of interoperable, integrated and consumer-focused health and human services systems" for Hawai'i. It does not include the State-based Marketplace (SBM) component of the system that the Hawai'i Health Connector was to fulfill and now Healthcare.gov offers. The following federal agencies provide oversight and funding for its development and ongoing maintenance:
        i. DHHS: Centers for Medicare & Medicaid Services (CMS) for Medicaid, Children's Health Insurance Program (CHIP), and State-based Marketplaces (SBM)

[1] More information on state plans for verification: http://www.medicaid.gov/medicaid-chip-program-information/program-information/eligibility-verification-policies/eligibility-verification-policies.html#footnote1

ii. DHHS: Administration for Children and Families (ACF)
    1. Office of Family Assistance (OFA) for the Temporary Assistance for Needy Families (TANF) program
    2. Children's Bureau (CB) for Child Welfare
iii. USDA: Food and Nutrition Service (FNS) for the Supplemental Nutrition Assistance Program (SNAP)

b. **KOLEA** is the online Medicaid eligibility application that sits on the DHS Enterprise System and determines Medicaid eligibility for Hawai'i residents. We refer to it as the "KOLEA application" or the "KOLEA app." Its purpose is eligibility determination and *not* "eligibility and enrollment." There is an interface with the enrollment system.

2. **Procurement and contract modifications**: Readers may expect that an audit of the KOLEA project resulting from Act 119, Session Laws of Hawai'i (SLH) 2015, would include more information about procurement and the contract modifications listed in Act 119, SLH 2015. If the brevity of this section of the audit report is related to the resolution of a protest, a brief explanation may help provide the larger context.

3. **CMS Pilot Program:** This offers a glimpse of the scope of eligibility error rates rather than a benchmark.
    a. Background: The focus and purpose of the Medicaid/CHIP Error Review Pilot (MCERP) is *not* to be used to imply or used to determine "error rates." The purpose of the pilot is to assist CMS in developing Payment Error Rate Measurement (PERM) and Medical Eligibility Quality Control eligibility review requirements under ACA. The eligibility review pilots provide a testing ground for different approaches and methodologies for producing reliable results and is being used to help CMS' approach to rulemaking that it will undertake prior to the resumption of PERM eligibility measurement component in FY 2017.
    b. The auditor's analogy of error findings is a generalization and should not be used as an error rate measurement as that is not its purpose.
    c. CMS recommends that states utilize the MCERP findings at this time to assist with prioritizing modifications and amending of state plan, rules, and procedures.

III. Response to the audit context, process, and findings

As you are aware, the circumstances behind this audit request were not typical because DHS requested a review of the Department of Human Services (DHS) KOLEA application in early 2015. Section 131 of Act 119 (2015), states that "the auditor shall conduct a management and financial audit...which shall include an evaluation of the procurement of the KOLEA system and the proposed addition of other department of human services program functions...all contract modifications, planning for ongoing maintenance and operations for the KOLEA system,

effectiveness of staff training on and utilization of the KOLEA system, and an analysis of the KOLEA system's current capabilities."[2] The scope of the audit is broad and requires a careful analysis and understanding of the ACA, its requirements related to Medicaid and insurance exchanges (also known as State-based Marketplaces), and the history related to the development and implementation of the KOLEA app and the Hawai'i Health Connector system to accurately assess the process, effectiveness, and outcomes related to the application.

Although auditors are not subject matter experts in the numerous fields in which they conduct reviews—and are not expected to be—the Patient Protection and Affordable Care Act (Public Law 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), is over 900 pages and complex, and the related federal rules and guidance also continue to evolve as they are refined. To assess compliance with the ACA (as it is more commonly known), it is necessary to understand the law and its rules and requirements. For this audit, it is also crucial to delve into the interconnected history of the Medicaid and State-based Marketplace because it is central to understanding the implementation of the KOLEA application. A firm grasp of both these fundamental components is necessary for a financial and management audit of the KOLEA app.

We will therefore provide a brief summary of the ACA goals and requirements related to Medicaid, explain the interwoven history of the Hawai'i Health Connector IT system and the KOLEA app, and provide objective information about the effectiveness of the application. We will then address specific points in the audit report.

ACA Goals

Many of the Affordable Care Act's programs are based on the Institute for Healthcare Improvement's Triple Aim: 1) improve healthcare quality, 2) reduce healthcare costs, and 3) improve population health.[3] It is a landmark law that fundamentally shifts healthcare delivery from the quantity of procedures to the quality of care as measured by cost and health outcomes. A founding principle of the ACA is that health coverage (i.e., insurance) positively impacts individual and population health, so a significant part of it focuses on increasing access to health coverage through Medicaid expansion and the creation of insurance exchanges. Some states opted to use the Federally-facilitated Marketplace (FFM), Healthcare.gov, while Hawai'i decided to build a State-based Marketplace (SBM) that became the Hawai'i Health

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[2] SECTION 131. Provided that the auditor shall conduct a management and financial audit of the department of human services' KOLEA system, which shall include an evaluation of the procurement of the KOLEA system and the proposed addition of other department of human services program functions, such as supplemental nutrition assistance program and temporary assistance for needy families, all contract modifications, planning for ongoing maintenance and operations for the KOLEA system, effectiveness of staff training on and utilization of the KOLEA system, and an analysis of the KOLEA system's current capabilities; and provided further that the auditor shall submit the findings and recommendations of the audit to the legislature at least twenty days prior to the convening of the regular session of 2016.

[3] Institute for Healthcare Improvement (2013). IHI Triple Aim Initiative: www.ihi.org/offerings/Initatives/TripleAim/Pages/default.aspx

Connector. The ACA requirement for an integrated eligibility and enrollment system was to have been met through the functions shared between these two entities.

As a result of the focus on increasing access to health coverage, Congress set forth an ACA requirement that eligibility be streamlined across Medicaid, CHIP, and health insurance exchanges. This policy is often referred to as "no wrong door" so that when an individual shows up, he or she is placed into the appropriate program, and it represents the ACA requirement for Medicaid programs that is relevant to this audit.[4] In other words, the ACA goals for Medicaid eligibility systems are: 1) to improve access to Medicaid, CHIP, and state-based marketplace coverage and 2) streamline eligibility.

However, there is *no* ACA requirement that other human services programs (e.g., SNAP, TANF) be included in this streamlined eligibility system. The three relevant federal agencies (often described together as the "Tri-Agency") involved—HHS-CMS, FNS-SNAP, and ACF-CB—provide coordinated oversight and funding for the integration of SNAP, TANF and Child Welfare applications on state enterprise systems, and they do encourage and promote integrated eligibility systems.

Larger Context and History: KOLEA application and Hawai'i Health Connector system

The Affordable Care Act represented the biggest change to Medicaid since its 1965 inception, and building the new and required eligibility system meant concurrent implementation by the state's Medicaid program under DHS and the state-based marketplace, the Hawai'i Health Connector. Both entities' components were to have made up the single, integrated eligibility and enrollment system required under the ACA. Planning and implementation by DHS was complicated by two significant factors:

1. Delayed federal guidance that impacted DHS' ability to implement changes within the required timeframe.
2. Having to change directions of the IT build due to complications created by the Hawai'i Health Connector.

History: Delayed federal guidance

The ACA significantly impacted multiple areas of the State's Medicaid rules, including eligibility, coverage, appeals, treatment of noncitizens, and interaction with the yet-to-be-formed Hawai'i Health Connector. Most significant were the changes to the eligibility requirements, which were hampered by the fact that ACA-related amendments to Medicaid regulations were not issued until March 2012, and updated as late as July 2013 (a few months prior to go-live in October 2013).

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[4] From CMS: www.medicaid.gov/affordablecareact/provisions/eligibility.html and www.medicaid.gov/affordablecareact/provisions/downloads/medicaid-eligibility-and-enrollment-final-rule-section-by-section-summary.pdf (p. 6).

State administrative rules must be based on statutory and, in this case, federal regulations. The DHHS' interpretation of the ACA and decisions on implementation direct the states' decisions and plans, and there are many steps involved:

- Numerous Notices of Proposed Rulemaking (NPRMs) were issued for federal regulations relating to operation of the Marketplaces and Medicaid programs, with no certainty as to date of finalization.
- The federal Medicaid regulations regarding eligibility were finalized on March 23, 2012, and other key federal Medicaid regulations, including some amendments to eligibility regulations, were finalized by CMS on July 15, 2013, which was only two and one-half months before the October 1, 2013 go-live date for the state's integrated eligibility system.

History: Complications created by the Hawai'i Health Connector

The Hawai'i Health Connector (Connector) was created by Act 205, SLH 2011, as a private non-profit entity and was not subject to sunshine law or state procurement. State documentation shows it was not transparent with the department, which created great uncertainty and delays in decision-making, and there was often failure of or refusal by the Connector to cooperate with the State.

The Connector's multiple decision changes caused DHS to change its design, development and implementation (DD&I) plans to accommodate the Connector. These severely impacted the ability of the Department to focus on completion and refinement of the KOLEA app.

In addition: For the systems development work, the State Office of Information Management and Technology (now known as the State Office of Enterprise Technology Services) was inserted to coordinate systems development between DHS and the Connector. Unfortunately, the arrangement between the three organizations introduced additional complexities. The then-State Chief Information Officer (CIO) arranged for the establishment of an integrated Project Management Office (IPMO) and, after a Technical Summit, issued a series of decision memos.

The following provides a summary of the events that impacted the Department's ability to focus on the timely completion of the KOLEA app:

1. January 2, 2013: CMS CCIIO (the Connector's federal oversight agency) approves the Connector's Blueprint that identifies DHS as the organization to perform intake and eligibility for all financial assistance programs including Medicaid and Advanced Premium Tax Credits (APTC). The means the Connector would have provided the Qualified Health Plans (QHP) presentation and selection functionality.
2. June 17, 2013: The State CIO issues a decision memorandum which identifies DHS as the organization performing intake for all financial assistance including Medicaid and

APTC and now also QHP presentation and selection. Once a person selects the QHP, the selection will be sent to the Connector.

3. July 8, 2013: The Connector requests a change to the June 17, 2013 Decision Memo (between the State CIO, DHS, and the Connector), and the decision is finalized in a Transition Memo in which the Connector will perform anonymous browsing, eligibility determinations for APTC, and QHP plan presentment and selection for QHP eligibles. DHS' involvement is limited to intake for all applications and performing determinations for Medicaid. This means DHS will send files to the Connector to enable the Connector to perform APTC determinations and QHP enrollment.
4. October 1, 2013: DHS goes live with KOLEA and begins sending files in the agree-upon XML format to the Connector on October 2, 2013.
5. September 5, 2014: Due to the inability of the Connector system to completely process the XML files sent by KOLEA, DHS agrees to continue the XML interface but also design and implement a process to create and send files in a PDF format of information on all individuals denied for or terminated from Medicaid. This would enable Connector personnel to manually review and enter the information into the Connector's system to make an APTC determination. This resulted in KPMG Supplemental Contracts No. 8 and 9, and DHS deferring upgrades to KOLEA to perform this function on behalf of the Connector.

As noted by the Auditor (p. 5), five (5) of the nine (9) KPMG contract amendments were required to address the changing needs of the Connector. Exhibit 1.2, *Summary of KPMG Contract Modifications*, including the draft audit report, does not break out development and maintenance & operations (M&O). A more detailed breakout is presented below:

Total costs for design, development and implementation	$115,575,017
Maintenance and Operations (Oct 1, 2013–Dec 31, 2015)	$ 30,920,651

Of the total $115.6 million for DD&I, $1,166,690 of the work was performed and paid by the Connector through contracts amendments 3, 4 and 5. The work under contracts amendments 8 and 9 for $995,000 were also performed and paid by the Connector. The remaining amount, $113,413,327, for DD&I performed for DHS was paid with a combination of federal and state funds. The federal government contributed 90% or $102 million while the state contributed 10% or $11.4 million.

For maintenance and operations, $700,000 was to be paid by the Connector for the files in PDF format. This amount cannot be charged to the federal and state government. The remaining amount, $30,220,651, has been and will be paid at 75% or $22.7 million by the federal government and 25% or $7.5 million by the state.

History: ACA compliance

As stated in the draft audit report (p. 6), "[i]n early 2015, CMS found the Connector to be non-compliant with the ACA because of unresolved IT issues, a non-integrated eligibility enrollment system, and lack of financial sustainability." In contrast, the Department of Human Services Med-QUEST Division (MQD)—the State Medicaid Program and its system—is CMS-compliant under the Affordable Care Act. The one risk for non-compliance for the Medicaid program in 2015 was if the State did not either fix the Connector system or build the connection from the Medicaid program to the Federally-Facilitated Marketplace (FFM), Healthcare.gov. After examining the full picture, including costs and efficiencies, Governor Ige selected the second option. DHS building new functions to connect with Healthcare.gov meant a significant amount of IT work in a very short amount of time (five months). This was accomplished in time for the start of the November 1, 2015 open enrollment and the reason for the additional costs (p. 6).

Audit Process

Data Collection: A working knowledge of the ACA and its goals and the history of the concurrent activities of the state Medicaid program and the Connector are critical to a comprehensive understanding of the development and implementation of KOLEA. Also essential would be a more comprehensive approach to qualitative data collection. At minimum, documentation from the federal agency, CMS, that provides oversight and about 90% of the funding for building the KOLEA app would be key.

Qualitative data collection. DHS acknowledges the importance in and value of qualitative data collection from parties involved in the audit process but observes that the sample of those interviewed is both small and selective. Neither the previous Med-QUEST Administrator nor CMS (both heavily referenced) were interviewed nor were community eligibility workers, providers, or applicants/beneficiaries.

Without this knowledge base for informing conclusions, auditors only relied upon interpretations of statute and contracts as well as the veracity of a few key informants who were interviewed. The detailed addendum with corrections, comments, and clarifications demonstrate the limitations, inaccurate findings and conclusions due to this approach.

Please note: On a January 29, 2015 call with CMS officials, the director of the CMS Center for Medicaid and CHIP Services' Data Systems Group stated that CMS has high confidence in KOLEA's determination of Medicaid eligibility and with both its accuracy and timeliness. On November 2, 2015—one day after the start of open enrollment—this was affirmed in writing by relaying "our confidence in Hawai'i's readiness." In reference to the functions that were built to connect to the FFM: "Account transfer and MEC were built, tested and are currently deployed. Your online application, MAGI rules and verifications continue to function as designed." In fact, Hawai'i is one of only two states in the country (Idaho is the other one) that has successfully implemented all Medicaid programs (MAGI and MAGI-excepted) in its eligibility application.

Thus, the conclusions and assumptions of this audit are incomplete and faulty because there is not a solid foundation based on factual history and understanding of the ACA, nor a balanced collection of qualitative data on the KOLEA application's implementation and current capabilities. Therefore, DHS disputes the two main audit findings because they are incorrect. We will address each broadly. An addendum is included with detailed comments, clarifications, and corrections.

Audit Findings

DHS rebuts the two primary findings as presented in the draft audit report:

1. The Department of Human Services did not properly plan for or implement the KOLEA [app]. As a result, the department cannot achieve the goals of the federal *Affordable Care Act*—to create a simple, real-time eligibility and enrollment process that uses electronic data to ease the paperwork burden on applicants and state agencies while expediting eligibility determinations.
2. The [DHS Enterprise System], which is a Medicaid enrollment and eligibility platform, is not integrated with DHS' other health and human services programs, such as SNAP and TANF. It therefore does not yet support the ACA's goals of facilitating individuals' enrollment in programs other than Medicaid.

First finding (p. 15) is inaccurate:

- The Department of Human Services (DHS) has met the goals of the Affordable Care Act with its KOLEA app: it provides an opportunity for individuals to apply online, is connected to the federal data services hub to conduct electronic verifications, and determines Medicaid eligibility in a timely and accurate manner, as confirmed by its federal oversight agency, CMS.
- The auditor is incorrect that KOLEA is an eligibility and enrollment application: the integrated eligibility and enrollment system required by CMS under the ACA was to have been met by both DHS and the Connector, with DHS responsible for eligibility. DHS fulfilled all the requirements for the Medicaid eligibility component.
- Planning was delayed because of the lateness in federal guidance. While the ACA was enacted in 2010, the Centers for Medicare and Medicaid Services (CMS) did not release policy guidance, Notice of Proposed Rule Making (NPRM), until at least a year from the date of enactment. Initial federal regulations for both exchanges and Medicaid programs were not implemented until March 2012, and final rules not released until July 2013, less than three months before the October 2013 go-live date.
- Despite the delayed federal guidance, there is clear documentation that multiple Policy and Division staff contributed substantively to the interpretation of the ACA and to the development of rules and provided guidance in the development of KOLEA. .
- The KOLEA app does use "electronic data to ease the paperwork burden on applicants and state agencies while expediting eligibility determinations."

- The app electronically verifies citizenship, social security number, Medicare and Social Security income benefits, and Supplementary Security Income (SSI).
- For on-the-ground evidence of timely eligibility determination: An October 1, 2015 statement by the then-director of the Connector outreach program confirmed at a legislator's COFA Task Force meeting that she could assist a client with entering information, pause for a few minutes to "talk story," log back on, and view the determination.

Second finding (p. 16) is incorrect:

- The original terminology used "KOLEA" for both the DHS Enterprise System (the "platform") and the eligibility app. It appears that this point references the DHS Enterprise System.
- The auditor is incorrect that either the KOLEA app or DHS Enterprise System is responsible for eligibility and enrollment.
- The auditor is also incorrect that there is an ACA goal of "of facilitating individuals' enrollment in programs other than Medicaid." There is *no* ACA requirement that other human services programs (e.g., SNAP, TANF) be included in this streamlined eligibility system.
- CMS set forth an ACA requirement that eligibility be streamlined across Medicaid, CHIP, and health insurance exchanges.[5]
- DHS continues to move forward with its plan to integrate SNAP, TANF and Child Welfare apps on DHS Enterprise System, but the timeline has been continually pushed back due to complications related to the Connector, the need to build functions to connect to the FFM (Healthcare.gov), and the current transition of the Connector functions to the State.

For these reasons, DHS disagrees with and rebuts the two draft audit report findings. KOLEA both achieves the ACA goals and meets all of its requirements for a Medicaid eligibility determination application.

Conclusion

Thank you to the State Legislature for requesting this audit and to the State Auditor for conducting it. Although it did not address all the areas on which DHS had sought clarity, we do appreciate receiving feedback on our work, team, and programs. As intended, we will use the final audit report as a tool for continued improvement.

In closing, we will share a little about where KOLEA is now, both in maturity and functionality. The KOLEA app provides the following ACA-required features:

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[5] From CMS: www.medicaid.gov/affordablecareact/provisions/eligibility.html and www.medicaid.gov/affordablecareact/provisions/downloads/medicaid-eligibility-and-enrollment-final-rule-section-by-section-summary.pdf (p. 6).

- A public portal to allow individuals to apply online
- Connection with the federal data services hub to conduct electronic verifications
- A new single streamlined application process that continues to be refined

All were completed and perform as intended, and the eligibility staff is able to process more applications and perform eligibility determinations for MAGI in less time. KOLEA capability is partially demonstrated through the following statistics and with no increase in eligibility workers:

September 2013 (month prior to KOLEA go-live)

- Total applications received to process: 8196
- Total processed: 6084
- Percent processed: 74%

November 2015

- Total applications received to process: 5764
- Total processed: 5255
- Percent processed: 91%

Due, in part, to the complexity of the Affordable Care Act and the complications resulting from multiple and changing parties and plans, KOLEA has been "wrapped up" and confused with the outcomes of other publicly-funded IT projects. The Med-QUEST Division's KOLEA app is one of Hawai'i's IT successes because it was implemented on time, and it meets federal requirements. It is also part of the Department's larger work to build an integrated eligibility system to truly improve the client experience and streamline efficiencies both inside and outside government. We recognize that the investment in building KOLEA and the DHS Enterprise System is significant—even if the federal government is funding 90% of it—and DHS continues to work with the State Office of Enterprise Technology Services in its plan to leverage the System, use it for other departments, and decrease maintenance and operations costs.

This is the first time that an objective State entity reviewed KOLEA, and we appreciate your feedback and recommendations for continued improvement. Thank you for providing this opportunity to respond to the draft audit report.

Sincerely,

Rachael Wong, DrPH
Director

Enc: *Addendum of Detailed comments, clarifications, and corrections*

Addendum: Detailed comments, clarifications, and corrections

- **KOLEA functions** (p. 4): This list of functions was revised over time and per agreement with the State CIO and the Connector. As stated in the body of the response, the plan for implementation was amended several times due to changes in direction taken by the Connector. This caused the DHS team and vendor to revisit and revise the design multiple times.
- **Document imaging** (p. 5): This should state that "another division's system could not fully meet the document imaging needs of *the Med-QUEST Division.*"
- **Contract amendments** (p. 5):
    - Initial contract and relevant modifications include both development and Maintenance & Operations (M&O) costs, not just development.
    - Supplements 3, 4, 5 show that DHS was asked to do more analysis and study to integrate with the Exchange which diverted attention and effort from implementing KOLEA app.
        - The descriptions for contract supplements 8 & 9 are not correct. The report identifies these two supplements as allowing the Connector to make initial eligibility determinations and to allow DHS to make intial eligibility determinations. However, those are not accurate descriptions of the amendments.
        - Since go-live October 2013, DHS had been sending to the Connector all Medicaid determinations in an agreed-upon XML format, and the Connector was supposed to use the files to make APTC/CSR determinations. However, the Connector's system was not able to fully process the Med-QUEST files resulting in a large backlog of applications in the first Open Enrollment period.
    - Given the Connector's first year's operating experience, DHS, the then-State CIO, and the Connector began discussions on how to improve the interaction between the two systems for the second Open Enrollment period. The resulting agreement approved by the federal partners was for DHS to create and send files in PDF format of applicant information for those individuals denied and terminated from medical assistance. These files would be sent daily in addition to the files in XML format. This necessitated contract amendments 8 and 9 to implement this functionality for the Connector, which was successfully implemented November 15, 2014.
- **Additional contracts** (p. 5): PCG, SH Consulting, and IBM did not develop KOLEA, but did support the development.
    - PCG is the Independent Verification and Validation (IV&V) contractor. IV&V is required on IT contracts by CMS. The IV&V contractor provides management

with an independent perspective on project activities and promotes early detection of potential risks. This allows a project to implement corrective actions to bring the project back in-line with expectations. The IV&V vendor also enhances management insight into the process and risks and validates a project's product and process to ensure compliance with requirements. PCG provided regular reports to the MQD Administration and KOLEA Project Team therefore keeping the project and build of KOLEA in line with expectations.

  - SH Consulting assisted with interfaces with HAWI and HPMMIS, Hawai'i's Medicaid Management Information System.
  - IBM made improvements to the MQD's network.

- **Contract to build connection to Healthcare.gov** (p. 5): KPMG received an exemption from bidding—*not* a sole-source contract—to build the new interfaces required by the FFM because while other companies might be qualified to do the required work, KPMG was the only vendor willing and able to meet the short timeframe for the implementation of the connection to the FFM. The short timeframe for implementation made the project high risk.
- **Med-QUEST Division responsibilities** (p.8): All of the five (5) MQD offices and branches have been and are involved with KOLEA, not just the Customer Services and Eligibility Branches.
- **RFP** (p. 13):
  - The report stated the auditors "reviewed the department's procurement processes, including its issuance of RFPs, bid awarding, contract modifications, and monitoring of deliverables related to the KOLEA" and the IV&V contracts, but there is no substantive discussion of how any of this impacted conclusions.
  - Although the audit "found that the division submitted a flawed RFP for bid" (presumably the RFP for related to KOLEA, and not for IV&V), there is no discussion regarding any deficiencies in the RFP or procurement process.
  - All issues related to the RFP and contract modifications have been resolved.
- **ACA goals** (p. 15): Please see response in above sections.
- **Planning** (p. 16-18):
  - While the ACA was enacted in 2010, the Centers for Medicare and Medicaid Services (CMS) did not release policy guidance, Notice of Proposed Rule Making (NPRM), until at least a year from the date of enactment.
    - May 2011: Guidance on Exchange and Medicaid IT Systems released.
    - August 12, 2011: <u>Proposed</u> rules regarding Medicaid/CHIP Eligibility released

- March 2012: Final rules on Eligibility and Enrollment Policies released.

- Since the federal requirements form the basis for the Hawai'i Administrative Rules (HAR), State Plan, and other documents, DHS Med-QUEST was limited and hampered in its planning, preparation, and implementation.
  - The Med-QUEST Division did have internal planning meetings but could neither define nor finalize policies and procedures, as CMS did not release proposed rules until August 2011 and final rules until March 2012.
  - In order for the MQD to meet the go-live deadline, the project team initiated work in Fall 2011.
    - The Planning Advance Planning Document (PAPD) for Health Information Technology, which is required by CMS and must state the need and objectives as well as a project management plan and budget, was drafted in August 2011 and submitted to CMS on September 1, 2011. MQD received approval of the PAPD on October 20, 2011, which allowed the Division to continue to move forward with the RFP.
    - An RFP for an Eligibility System Consultant to write the Implementation APD, develop requirements, assist in writing the RFP for a system developer, and assist with evaluations was issued on December 5, 2011. Public Consulting Group (PCG) was awarded the contract for the Eligibility System Consultant Services on January 24, 2012, two months before the first final federal regulations relating Exchange and Medicaid functions under ACA were issued.
    - By necessity, therefore, the RFP for DHS' integrated eligibility system was drafted concurrently with the massive ACA-related administrative rule amendments (see discussion on Policy Office, below), and was issued on an accelerated schedule on August 27, 2012.
  - The federal government did not release final ACA-related amendments to Medicaid regulations until July 15, 2013, only two and one-half months before the October 1, 2013 go-live date.
  - Despite all the delays, KOLEA went live on October 1.

- **Policy Office** (p. 18): The Policy and Program Development Office (PPDO) was engaged in the planning process:
  - The PPDO administrator and one staff member also attended weekly meetings beginning in July of 2012 with the KOLEA team, branch

administrators, and Med-QUEST Administration to discuss policy and KOLEA implementation issues.

- All policy decisions made by PPDO were shared with Division staff.

- **Verification Plan** (p. 18): The Verification Plan is a plan for *electronic* verifications. It is *not* the document that describes the policy and procedures for all verifications and will not have the force of law. CMS recognizes that the Verification Plan can change over time as it is updated annually.
- **Verification Plan and HAR** (p. 19): Hawai'i Administrative Rules requires verification using the sources listed in Exhibit 2.1, but does not specify that verifications be done electronically. The Verification Plan does not prevent a worker from verifying financial information manually or logging in to HAWI.
- **Training** (p. 20-21):
  - Workers had desk references and workaround procedures at go-live, but it is not clear if they were widely distributed.
  - Eligibility branch supervisors have received several trainings from PPDO, as well as written procedures for MAGI-based eligibility determination and policy and program clarifications for issues that are unclear. PPDO was and continues to be available to assist Eligibility Branch staff with issues they cannot resolve using the information they have.
  - This being said, we recognize that training is an important component of any new and evolving process and that many eligibility workers felt they did not receive adequate training, especially before the go-live date, and still find KOLEA difficult to use (p. 23).
  - DHS and Med-QUEST Administration also recognize that investment in staff is important and therefore included business process re-engineering in its FY17 budget request to engage all staff in the transformation of Medicaid business processes using KOLEA.
  - One deficit is that the positions in the Training Office are currently vacant and have been difficult to fill. MQD Administration is examining the positions and discussing way to promote the filling of them.

- **Policy development** (p. 21-23):
  - RFP: The RFP development included input from the Eligibility Branch, so it is inaccurate to state that "the KOLEA project team developed its own recommendations...and included those...in the RFP requirements" (p. 21).
    - Representatives from different parts of the Division and outside the Division were invited to provide input into the RFP.
    - All requirements were reviewed with representatives from the Eligibility Branch.

- The Policy and Program Development Office (PPDO) was engaged in the planning process:
    - The PPDO administrator and one staff member also attended weekly meetings beginning in July of 2012 with the KOLEA team, branch administrators, and Med-QUEST Administration to discuss policy and KOLEA implementation issues.
    - All policy decisions made by PPDO were shared with Division staff.
- One person from PPDO was assigned full-time to the project team, which reflects the Division's commitment to the project. The specialist's interpretation and recommendations for the administrative rules were *not* the sole basis for the RFP.
- The description on page 22 is self-contradicting: In paragraph 1, only one person defined the policies; in paragraph 2, the program specialist received help from two other specialists; and in paragraph 3, the one person provided recommendations that "provided the basis" for a starting point discussion with other stakeholders. Based on this, the conclusion must be that other people were involved, and decisions did not rest with only one person.
- The entire Division was involved in development of ACA policies and procedures for Medicaid (p. 23), and followed best practices.
    - The Division held weekly meetings with all Division Branches to go over ACA proposed rules and discuss requirements, as well as options available to the State, so programming of the KOLEA could be done based on policies.
    - Decisions made by the group were recorded by the KOLEA Team to ensure programming by contractor would follow policies.
    - Options on which the group could not decide were taken by the Division Administrator to the Director for a final decision. The Director's decision was then communicated back to the workgroup and KOLEA Team.

- **Verification of self-reported income** (p. 23-24):
    - There is not a requirement that all verifications be conducted electronically. KOLEA does have data matching with DLIR, but the information is produced in a report that is manually worked.
    - DLIR is currently building a database that will be a copy of its production data, which will be accessible by DHS and other State departments to perform data matches without impacting its system's operational performance. DLIR will notify DHS when the build is completed. DHS and DLIR are working together on an MOU which is expected to be finalized and executed in 2016.

- **IRS interface** (p. 26):
    - Verification with IRS is not required, and DHS chose not to interface with the IRS 1040 data through the Federal Data Services Hub (FDSH) because the data was more than one year old and more current information is preferred. This was in the CMS-approved Verification Plan.
    - While an interface with the IRS could be established for unearned income (e.g., interest, dividends), it would also be old data and therefore of limited use and value. Additionally, most applicants do not report substantial income from these sources. The Department therefore, and as allowed by federal regulation, opted to not establish an interface with the IRS as it would not be cost-effective.
- **KOLEA Problems Reported by EWs** (p. 27):
    - DHS and MQD Administration take staff feedback seriously. The results of the auditor survey of eligibility workers are valued.
    - Responses to their identified issues follow:
        - Complex case processing: KOLEA processes cases correctly provided the user inputs accurate data, so additional training may be necessary to provide support to staff.
        - Generation of inappropriate notices: this is a known issue that MQD has been actively correcting and monitoring.
        - Defaults in place: Data validations do exist, so this may also require additional training to provide support to staff.
        - Varying functionalities: Need examples to address.
        - Lack of integration with Connector: KOLEA did provide data to the Connector system in a format it could receive, and there was operational coordination. The limited integration did not have an impact on Medicaid eligibility but did increase overall development costs.
- **Performance targets** (p. 28-29):
    - Volume and average processing times provide important benchmarks against the CMS requirements. By reviewing these measurements, the division can see how well the division is performing in processing applications for all Medicaid groups.
    - This being said, the Division will analyze and potentially expand the performance metrics from what currently collected. (p. 28).
- **Error rates** (p. 30): This 4.4% statistic is misleading. For the Medicaid/CHIP error, the majority of these individuals are eligible for Medicaid or CHIP coverage, but the individual was coded as a CHIP case instead of Medicaid or vice versa. Although

there may be a small payment error, these individuals were and are eligible for medical coverage.

- The focus and purpose of the Medicaid/CHIP Error Review Pilot (MCERP) is *not* to be used to imply or used to determine "error rates." The purpose of the pilot is to assist CMS in developing Payment Error Rate Measurement (PERM) and Medical Eligibility Quality Control eligibility review requirements under Affordable Care Act (ACA). The eligibility review pilots provide a testing ground for different approaches and methodologies for producing reliable results and are being used to help CMS' approach to rulemaking that it will undertake prior to the resumption of PERM eligibility measurement component in FY 2017.
- The auditor's analogy of error findings is a generalization and should not be used as an error rate measurement as that is not its purpose.
- CMS recommends that states utilize the MCERP findings at this time to assist with prioritizing modifications and amending of state plan, rules, and procedures.

- **Integrated human services system = DHS Enterprise System** (p. 30-36): The Department is building the *DHS Enterprise System* and plans to add SNAP, TANF, and other apps to it in concert with and support from the federal government. The timeline has been continually pushed back due to complications related to the Connector, the need to build functions to connect to the FFM (Healthcare.gov), and the current transition of the Connector's functions to the State. There are a few points to clarify:
  - **RFPs:** The department is *not* working on selecting vendors for its Benefits, Employment and Support Services Division (BESSD) and its Social Services Division (SSD)—it is working on the RFPs. At the time the auditor's project was underway, the estimated issuance of the RFP was December; it has been delayed for a few months (p. 31 and 36).
  - **IAPD:** At the time of writing, the department was providing drafts of its combined tri-agency IAPD to the federal partners (CMS, FNS, and CB). It has since been submitted, and the department is working on addressing comments and questions from the federal partners.
  - **Delays:** Despite the delays in issuing the BESSD and SSD RFPs, the Department plans to complete the system build by the end of 2018 to maximize the 90/10 federal fund support.