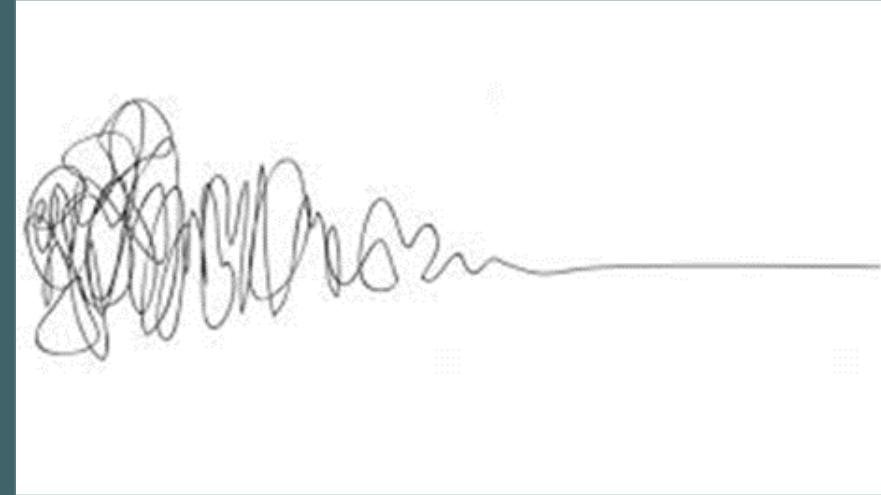


Building and Financing Infrastructure for Change



Mary Brogan, Administrator
Hawaii Development Disabilities Division

Mary Rapp
Public Consulting Group

June 14, 2024

Increased Compensation and Confusion

Many in the HCBS industry have noted that low rates themselves are driving the workforce turnover, not the percentage of people with disabilities. CMS responded that regulating rates would be difficult across states, as different costs of care and living around the country make regulation challenging. Starting with the proposed rule, CMS supported its use of the direct compensation pass-through floor by referencing several states that implemented "wage pass-through" provisions for extra Medicaid payments. For example, Minnesota allocated 72 percent of such funding, while Massachusetts apportioned 90 percent of such funding provided by the American Rescue Plan Act of 2021 to secure HCBS access to the workforce.

State Advisory Committee	Establish Performance Requirements	Ensure Payment Adequacy	Standardize HCBS
<ul style="list-style-type: none">Replaces Medical Care Advisory Committees (MCACs) with a new committee framework.Requires states to establish and operate the new Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG) to advise on health and medical services, matters related to policy development and effective administration.The agency director or higher state authority appoints members to the MAC and BAG on a rotating and continuous basis, through a state-defined process.	<ul style="list-style-type: none">New minimum performance requirements for 1915(c) waiver and applied to 1915 (i), (j), and (k) programs that replace the reporting requirements and the 86% performance level threshold for performance measures.States must demonstrate that a reassessment of functional need was conducted and that person-centered service plans are reviewed and updated as needed at least annually for at least 90% of individuals.Performance levels are effective for FFS systems 3 years after the effective date of final rule; effective for managed care systems, first contract rating period beginning on or after 3 years from date of final rule.	<ul style="list-style-type: none">States must provide payment rates that are adequate to ensure sufficient DCWs participate in FFS and managed care systems.States must meet the minimum performance level, calculated as the percentage of total payment for a service represented by total compensation to DCWs.At least 80% of all payments for homemaker, home health aide, and personal care services in HCBS programs must be spent on compensation for DCW; applies the 80% requirement to manage care.States must publish comparative payment rate analysis of Medicaid FFS rates to Medicare payment rates.	<ul style="list-style-type: none">HHS will identify and update at least one other year quality measures in the Quality Measurement System.State must report on a minimum performance level, calculated as the percentage of total payment for a service represented by total compensation to DCWs.At least 80% of all payments for homemaker, home health aide, and personal care services in HCBS programs must be spent on compensation for DCW; applies the 80% requirement to manage care.Requires states to demonstrate continuous quality improvement plans.States must implement a beneficiary grievance system in FFS HCBS programs.

Feeling some analysis paralysis?

Access Rule: HCBS



Rate and Access Transparency

- By January 1, 2026, states must publish all Medicaid FFS payment rates on a publicly accessible website.
- States must provide CMS new information when they propose to reduce provider payment rates or structure provider payments in a manner that could diminish access to necessary care, ob-gyn, and mental health services.

Rate Restructuring

- States must provide CMS new information when they propose to reduce provider payment rates or structure provider payments in a manner that could diminish access to necessary care, ob-gyn, and mental health services.
- Just demonstrate no more than a 5% reduction in aggregate expenditures for a single state.
- Restrictions would aggregate Medicaid rates for 90 percent of states.

Vicki Gottlieb, Deputy Director, Center for Medicare and Medicaid Innovation



Strategic Path Components

- Which parts HCBS Access Rule require data- and IT- related solutions?
- How will changes be financed and resourced?
- What can we build on?

AGENDA

- **Financing Change**
 - Messaging strategy for general fund budget increases
 - Rate increases
 - Compliance
 - Case Growth
 - Workforce Development
 - **Administrative Claiming**
 - **IT System Development**

Financing Change

or How to Stop Leaving Money on the Table

Medicaid Administrative Expenditures

- Title XIX of the SSA allows states to claim federal financial participation (FFP) at a payment rate of fifty percent (50%) for most administrative expenditures related to “proper and efficient” administration of its Medicaid state plan.
- Certain admin expenses at higher FFP
- Costs are supported by an allocation methodology in states’ approved Public Assistance Cost Allocation Plan (PACAP).



Show me the money!

Where is it?

1. Discovered our cost allocation plan embedded in the DHS PACAP

How can I get it?

2. Issued RFP to rewrite the CAP

How do I claim it?

3. Created a Department of Health-wide plan

Where will I put it?

4. Established a Medicaid Administrative Claiming Special Fund through legislative process

What do I want to buy?

5. DOH/PCG modernized Random Moment Survey

6. DOH submits claims

7. Reimbursed FFP is deposited in our Special Fund

8. Financed IT system build, advanced analytics, training, and positions



Core Elements of Administrative Claiming

Partnership with PCG

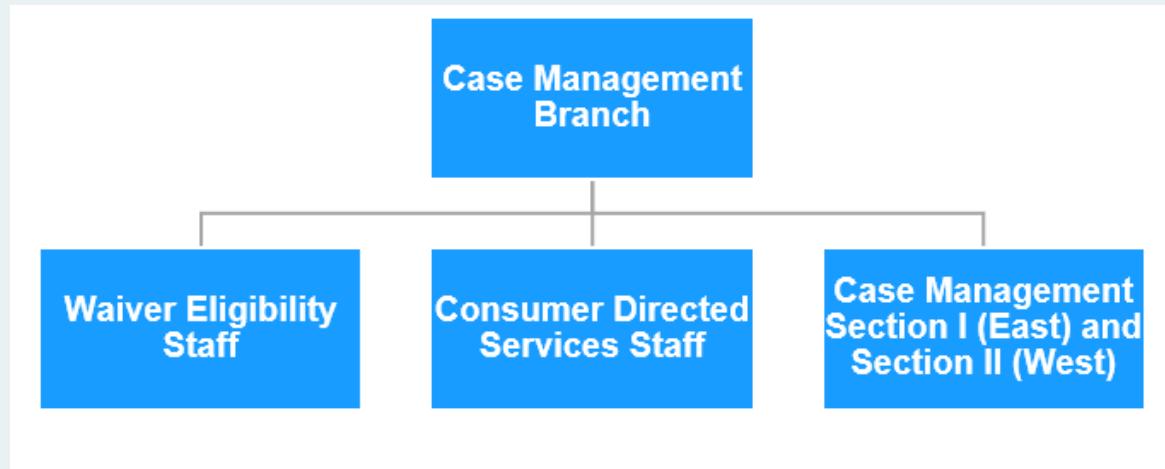
- PCG works with over 40 states nationwide to provide cost allocation services.
- DOH contracted with PCG to develop DOH's Cost Allocation Plan (CAP).
- Cost Allocation is the process of identifying and assigning costs to activities, people, projects, or other cost objectives. Its goal is to spread costs fairly across these units.
- A CAP is the “narrative” document that outlines functions performed by an agency and the methods used for allocating these costs to “benefiting” objectives – such as Medicaid.



*Appendix VI to Part 200
Public Assistance Cost
Allocation Plans*

Organizational Review

- Conducted interviews with DOH staff to begin CAP narrative development
 - What is the organizational structure?
 - What do staff work on? Do they only work on one activity or multiple activities?
 - Do staff perform Medicaid administrative activities?
 - What staff are working on enhanced FFP activities?



CAP Narrative

Name	Description	Allocation Method
Case Management Branch Administration	The Case Management Branch Chief and support staff oversee the day-to-day operations of the Case Management Branch, including management of the Branch's budget, personnel, and facilities.	Head Count across Case Management Branch
Consumer Directed Services	The Consumer Directed Services staff provide information, education, and assistance to individuals and families that choose to participate in the consumer directed services program under the HCBS I/DD Waiver. The staff also coordinate with the Department of Human Services (DHS) and their fiscal intermediary to provide payment to consumer directed staff.	Direct to Medicaid Administration at 50% FFP – CMS –64.10(W) Line 22
Case Management Section – Social Workers	The Case Management Section – Social Worker case managers provide targeted case management services to clients as outlined in the Medicaid State Plan, perform other Medicaid allowable and non-allowable activities, and provide case management services to clients that are not eligible for Medicaid.	DDD RMS
Supports Intensity Scale Unit	The Supports Intensity Scale Unit coordinates and administers the Supports Intensity Scale (SIS) system based on the SIS Assessment to assess the level and frequency of support needs and services. The unit maintains contracts and coordination of SIS-related contracts.	Allocated to Medicaid Administration at 50% FFP –CMS –64.10 (W)Line 22 and State Funds via the DDD Medicaid Eligibility Rate (MER)

Allocation Statistics – Time Tracking



- When staff work on multiple activities or programs that are funded by multiple funding sources and/or must be reported separately, and another methodology is not available, the required methodology for allocating costs is a time study
- PCG and DOH developed a random moment time study using PCG's EasyRMTS™ software to capture the level of effort of staff that work on various case management activities.
 - The RMTS allows DOH to capture administrative costs allowable for 50% FFP
 - PCG and DOH developed a 100% time tracking process (using Excel) for staff working on INSPIRE design, development, and implementation (DDI) and other activities
 - The time tracking allows DOH to capture administrative costs allowable for 90% FFP (and for future 75% FFP once in M&O)

Final Medicaid Administrative Claim

- PCG implemented and operates our cost allocation processing system - AlloCAP™ - on DOH's behalf.
 - AlloCAP is used to process over \$70million of DOH's expenses each quarter.
- PCG uploads payroll data, enters allocation statistics (including EasyRMTS results), enters contract information and then "runs" the CAP in AlloCAP.
- PCG then compiles a final Medicaid administrative claim summary and detailed workbook for DOH to submit to the State Medicaid agency.
 - AlloCAP provides the final results grouped by CMS-64 reporting line, including costs allowable for enhanced FFP.



EXAMPLE

For Quarter Period: January 1, 2023 - March 31, 2023

HI DOH CAP Medicaid Administrative Claim

SFY23 Q3 Medicaid FEDERAL SHARE ONLY	AMHD	CAMHD	EIS	DDD	DOH Other	TOTAL
Medicaid 50% FFP CMS 64.10 Line 22	\$100.00	\$500.00	\$100.00	\$1,000.00	\$500.00	\$2,200.0
Medicaid 50% FFP CMS 64.10(W) Line 22				\$100.00		\$100.0
Medicaid 50% FFP CMS 64.10(W) Line 22 ARPA				\$100.00		\$100.0
Medicaid SPMP 75% FFP CMS 64.10(W) Line 3b				\$300.00		\$300.0
Medicaid PASRR 75% FFP CMS 64.10(W) Line 10				\$150.00		\$150.0
INSPIRE Medicaid 90% FFP CMS 64.10(W) Line 2A		\$100.00		\$200.00		\$300.0
INSPIRE Medicaid 90% FFP CMS 64.10(W) Line 2B		\$100.00		\$300.00		\$400.0
SFY23 Q3 Total Medicaid Federal Share	\$100.00	\$700.00	\$100.00	\$2,150.00	\$500.00	\$3,550.00

The above claim to Medicaid administration at 50% FFP, 75% FFP, and 90% FFP only includes approved expenditures that are allowable in accordance with the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR Part 200), Medicaid administration requirements in 42 CFR 433.15 and 432.50, and other applicable federal and state statutes, regulations, policies. These expenditures are based actual DOH expenditures from the State of State accounting and payroll systems and allocated in accordance with the DOH cost allocation plan. This claim also includes a breakdown of Medicaid administrative expenditures funded under the American Rescue Plan Act (ARPA) Section 9817 for the provision of enhanced Home and Community Based (HCBS) FMAP.

Name of DOH Official

Title

Signature

Date

What We Bought and Why

A love affair with innovation, measurement and accountability in systems.



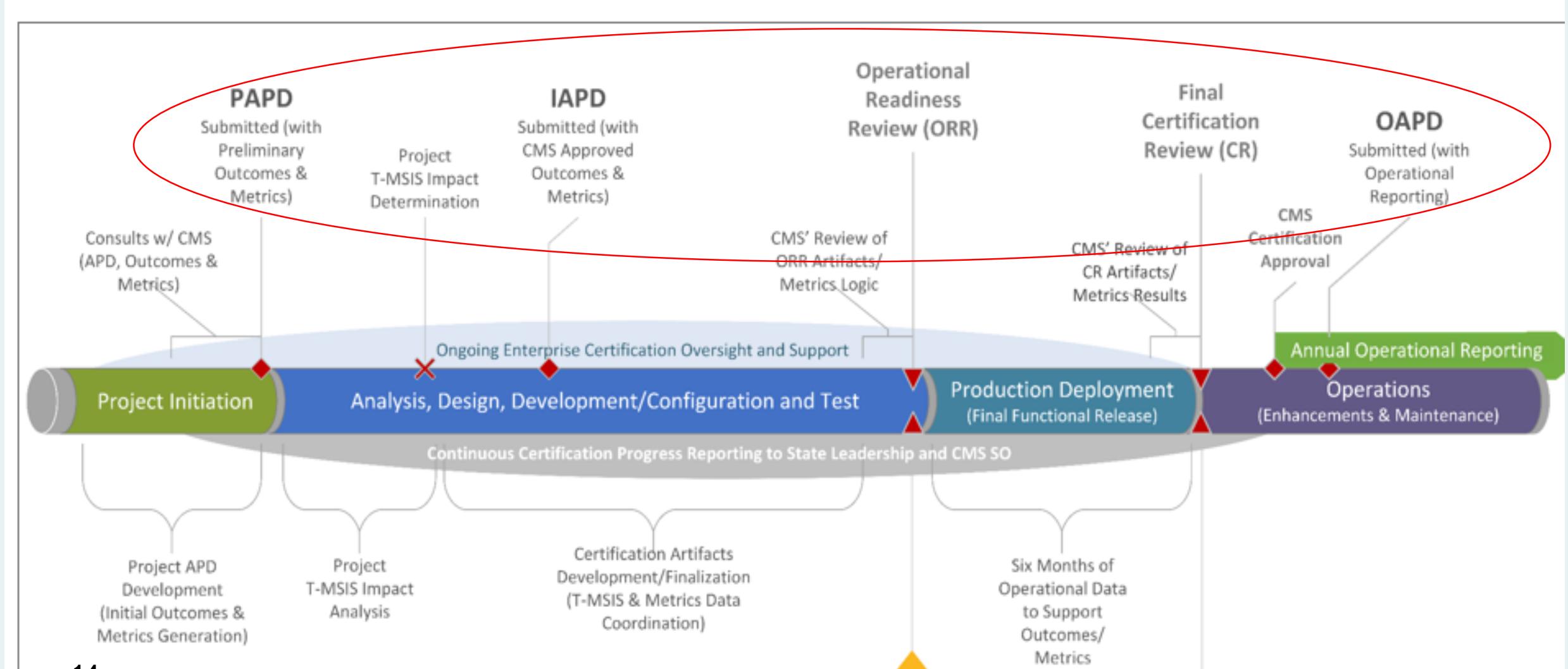
Build, tweak, or blow up?

Hawaii at the Crossroads

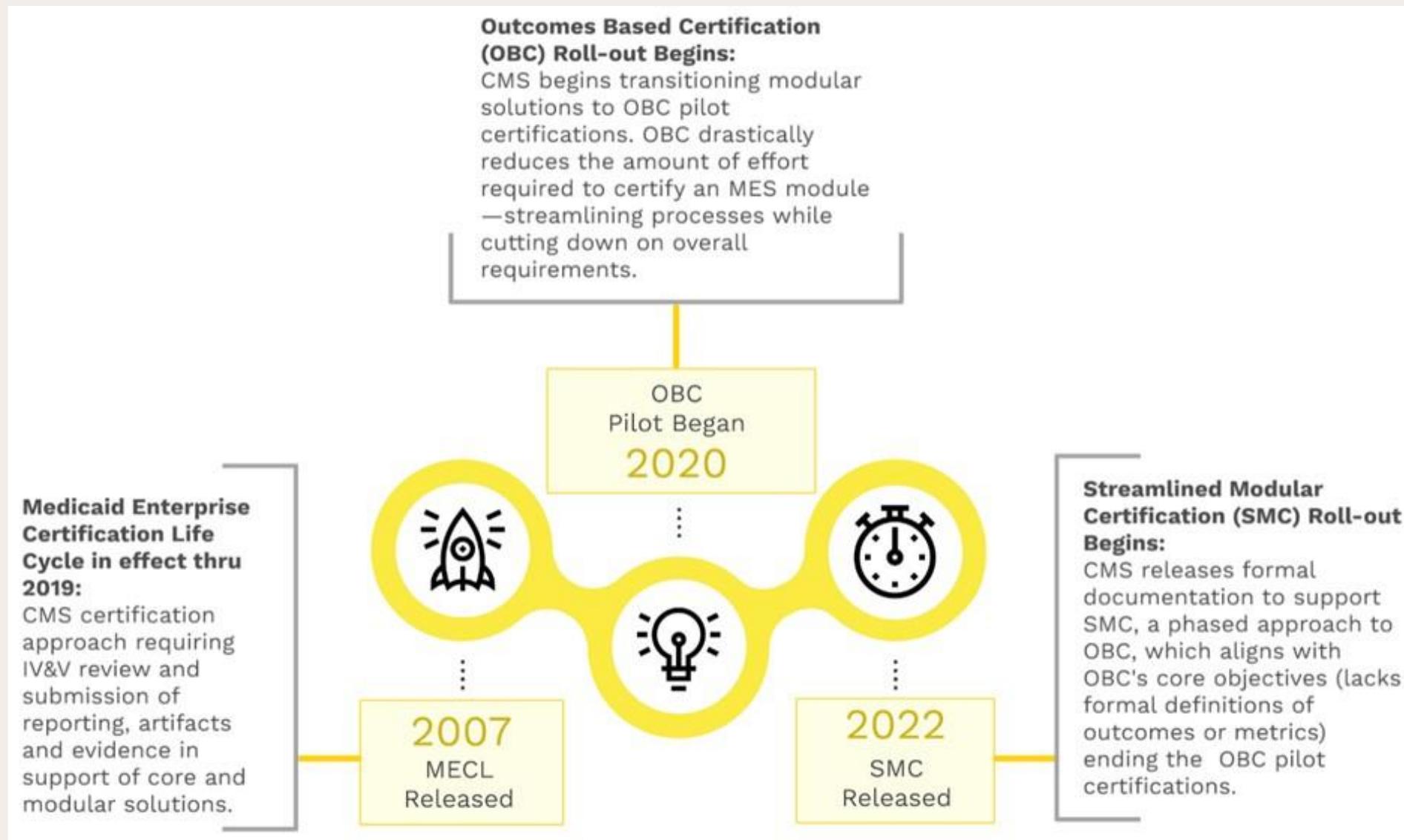
Hawaii's Process Roadmap for IT System Development

- Getting buy-in for INSPIRE
 - What is the approval process
 - Iterative Successes
 - Demonstrate value
- Best platform and build approach for Hawaii and why
- Big Rocks:
 - “Industry Trends” – the Writing on the Wall
 - User Needs
 - Best outcomes and system commitments

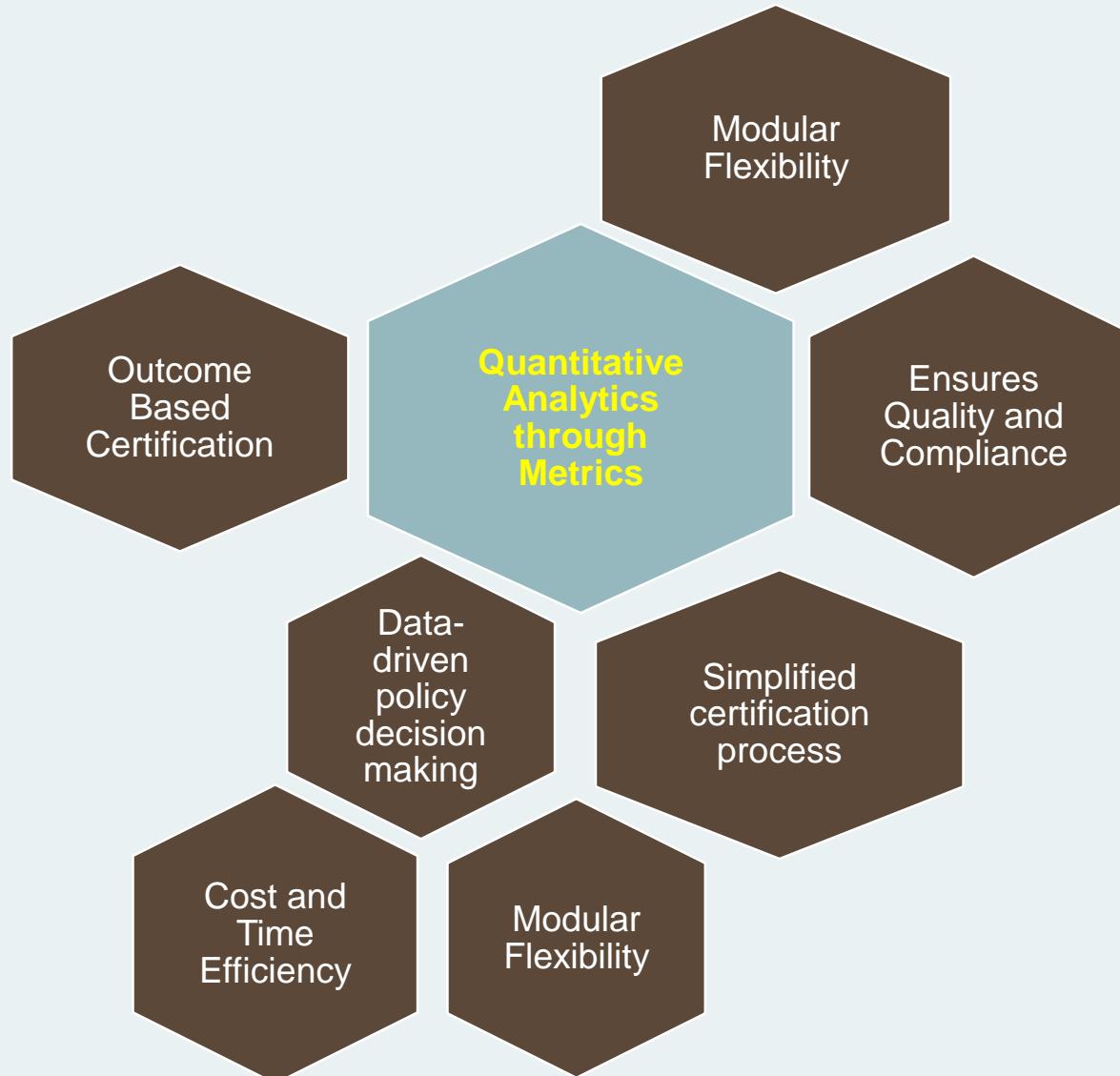




History of CMS Modular Certification



What is Streamlined Modular Certification?



Key Elements of SMC

Conditions for Enhanced Funding

- Documented on APD
- Compliance with CEF is shown through Evidence
- CEF evidences are documented in APD
- CEF evidences are demonstrated during ORR and CR as applicable

Outcomes

- CMS Required
- State Specific
- Reported on APD
- Demo during ORR and CR
- Mostly used as evidence for CEF

Streamlined Modular Certification

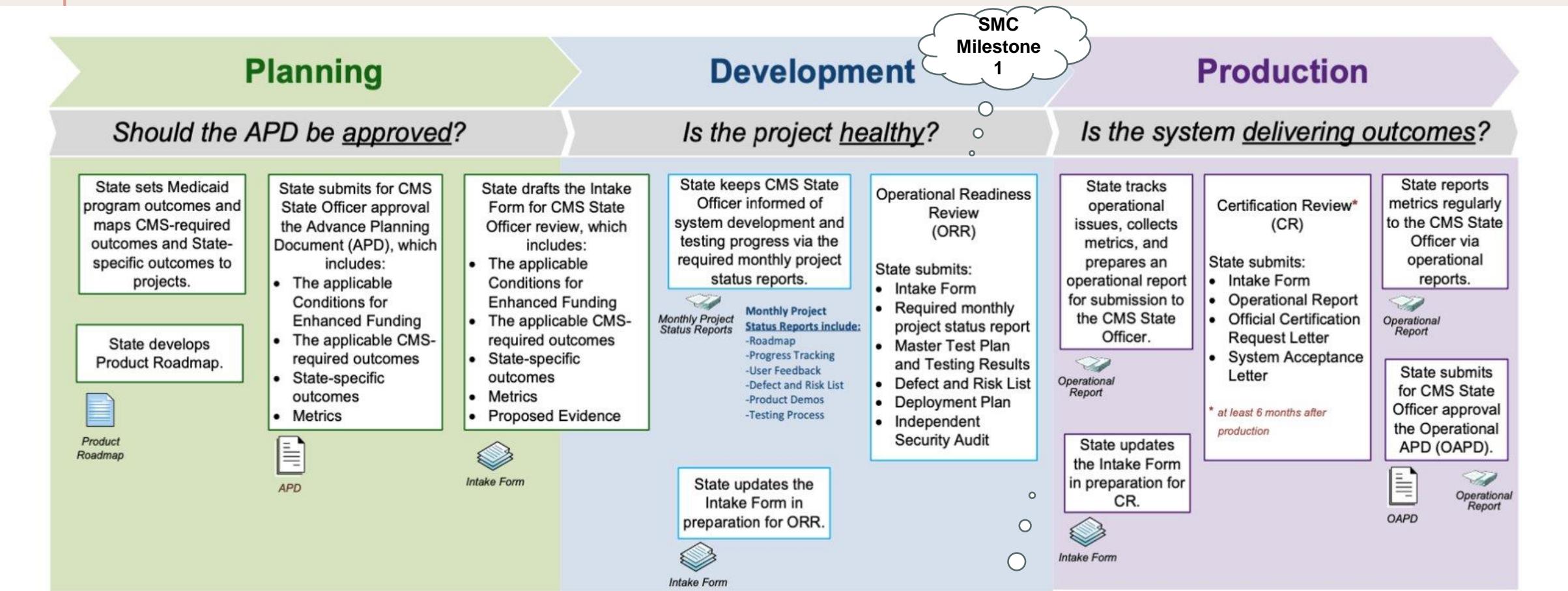
Metrics

- CMS Default on GitHub
- State Specific
- Reported on APD
- Demo during CR
- Documented on Operational Report Workbook(ORW)

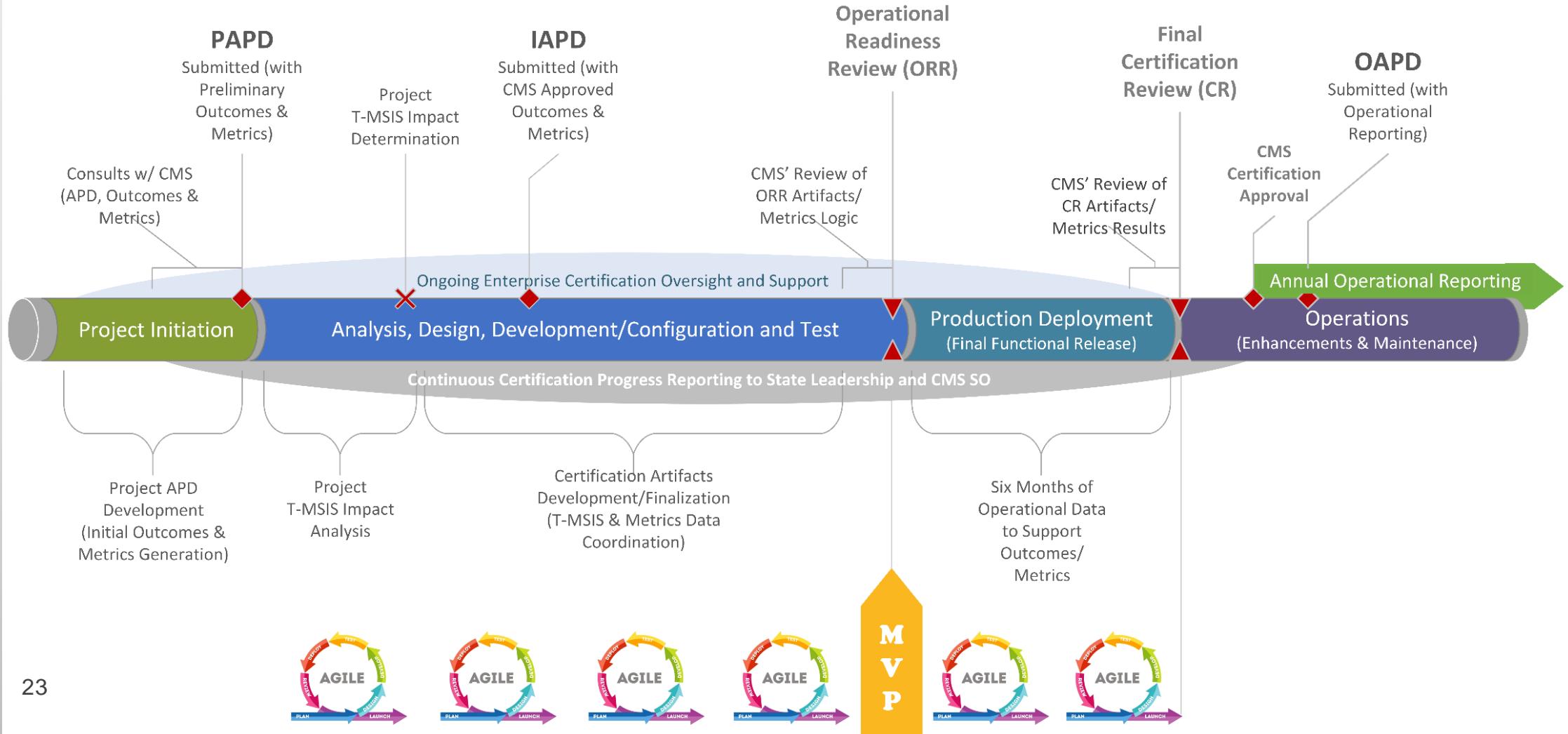
CMS Required Artifacts

15 required artifacts
Some are needed for ORR and some for CR

SMC Phases and Milestones



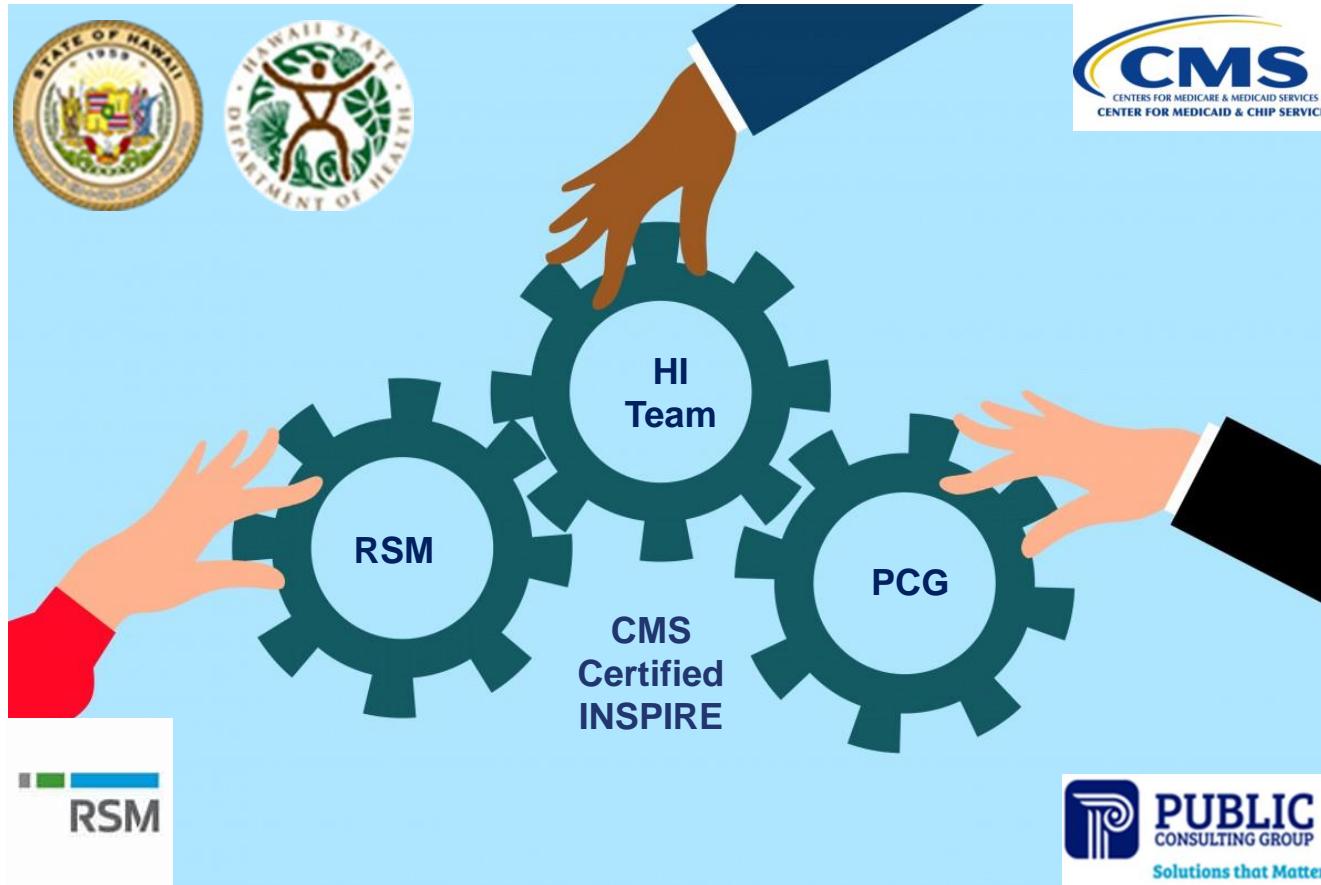
Integrating SMC Milestone Tasks into the Software Development Life Cycle (SDLC)



SMC Required Artifacts

#	CMS Required Artifacts for ORR, CR, or both	Required for ORR	Required for CR	RASCI-VS (Responsible, Accountable, Support, Consulted, Informed-, Verifier, Signatory)
1	Revised Intake Form	✓	✓	
2	Applicable APD (PAPD, IAPD, OAPD, APDU include applicable Conditions for Enhanced Funding as documented in Appendix A of the SMC certification Guidance Document. And O&Ms)	✓	✓	
3	Defined Outcomes and Metrics (documented in the APD and, as applicable, demonstration during ORR and CR)	✓	✓	
4	Conditions for Enhanced Funding (Document under APD and evidence demo)	✓	✓	
5	Monthly Project Status Report (Product Roadmap, Progress Tracking, user feedback, defect, and Risk list. Product demos and Testing process documentation as per Testing guidance Framework)	✓	✓	
6	Demo Presentation (showing how functionality is attained for applicable CEFs)	✓	✓	
7	Master Test Plan and Testing Results (Per the Testing Guidance Framework)	✓	✓	
8	Defect and Risk Lists (Must include items per Appendix C of the SMC certification guidance document)	✓	✓	
9	Deployment Plan (Must include items per the Appendix C of the SMC certification guidance document)	✓		
10	*Third-Party Security and Privacy Controls Assessment Report (Per Appendix D of the SMC certification guidance doc, CMS may require POAM after CMS review)	✓	✓	
11	Disaster Recovery Plan/Business Continuity Plan with Test Results (preferred at ORR and required at CR) For some States, such as CA, it is a required artifact and, if not presented, will be added as a finding by the CMS/MITRE at the ORR session.	✓	✓	
12	508 and ADA Compliance Results (preferred at ORR and required at CR)		✓	
13	Operational Reports (Metrics Reporting)		✓	
14	System Acceptance Letter (Entrance criteria for the CR)		✓	
15	Official Certification Request Letter (Entrance criteria for the CR)		✓	

Unlocking SMC Success: The Power of Collaboration, Coordination, and Communication Across Vendor and State Teams



Financing Results for INSPIRE

- We have financed 69% of overall costs through administrative claiming.
- Most of the reimbursements are reinvested into INSPIRE
- Better positioned to refine, add, tweak
- Next: Analytics, Reporting, and Using the Data- foray into wisdom

Contract Year	Project Year	Project Contract Cost Totals								Projected Medicaid Reimbursement (90% DDI, 75% M&O) MER=92.3%
		Governor's Approved Budget	RSM (System Integrator)	Licenses and Security	PCG (IV & V)	Document Management	Impresys Software Corporation (Interactive Training Videos and Desk Procedures)	Report Writing	Revised Total	
Original	5/30/2017-5/30/2018	\$2,545,772	\$2,271,064	\$25,364	\$249,344	\$0	\$0	\$0	\$2,545,772	
Mod 1	5/30/2018-5/30/2019	\$3,104,396	\$2,686,373	\$168,681	\$249,342	\$0	\$0	\$0	\$3,104,396	
Mod 2	5/30/2019-5/30/2020	\$3,980,182	\$3,634,463	\$283,333	\$62,336	\$0	\$0	\$0	\$3,980,182	\$3,306,296
Mod 3	5/30/2020-5/30/2021	\$1,150,978	\$762,000	\$61,000	\$78,978	\$0	\$0	\$0	\$1,150,978	\$1,288,397
Mod 4	5/30/2021-5/30/2022	\$3,519,102	\$2,700,000	\$630,000	\$19,202	\$0	\$0	\$49,900	\$3,519,102	\$2,923,318
Mod 5	5/30/2021-5/30/2022	\$1143,691	\$984,603	\$0	\$59,088	\$0	\$0	\$0	\$1143,691	\$950,064
Mod 6	5/30/2021-5/30/2022	\$856,544	\$464,000	\$38,000	\$79,544	\$0	\$0	\$0	\$856,544	\$771,531
Mod 7	5/30/2022-5/30/2023	\$3,635,316	\$2,106,000	\$141,000	\$19,316	\$0	\$0	\$0	\$3,635,316	\$3,019,857
Mod 8	5/30/2022-5/30/2023	\$2,686,816	\$2,353,000	\$214,500	\$19,316	\$0	\$0	\$0	\$2,686,816	\$2,221,938
Mod 9	5/30/2022-5/30/2023	\$164,772	\$125,000	\$0	\$39,772	\$0	\$0	\$0	\$164,772	\$136,067
Mod 10/Closeout	5/30/2023-5/30/2023	\$0	-\$685,000	\$0	-\$39,772	\$0	\$0	\$0	-\$724,772	-\$602,068
Initial Contract	5/30/2023-5/30/2024	\$4,288,625	\$2,709,000	\$1996,668	\$307,729	\$0	\$0	\$0	\$5,013,397	\$4,164,629
Mod 1	5/30/2024-5/30/2025	\$0	\$2,793,000	\$1020,432,58	\$692,729	\$0	\$99,950	\$0	\$4,606,112	\$3,826,297
Mod 2	5/30/2025-5/30/2026	\$0	\$2,000,000	\$1020,432,58	\$307,729	\$400,000	\$0	\$0	\$3,728,162	\$2,567,089
	Total	\$27,476,144	\$24,903,503	\$7,692,411	\$2,664,653	\$0	\$0	\$49,900	\$35,810,417	\$24,537,955

Acronyms

SMC	Streamlined Modular Certification
ORR	Operational Readiness Review
CR	Certification Review
MR	Milestone Review
MVP	Minimal Viable Product
O&M	Outcomes and Metrics
CMS	Center for Medicaid Services
SMDL	State Medicaid Director Letter
APD	Advance Planning Document
FFP	Federal Financial Participation
DD&I	Design Development and Implementation
M&O	Maintenance and Operations
MES	Medicaid Enterprise System
RASCI-VS	Responsible Accountable Support Consult Informed-Verified signatory
ORW	Operational Report Workbook

Thank
you

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<https://health.hawaii.gov/ddd/>