
Audit of the Department of Human Services' KOLEA System: \$155 Million KOLEA Project Does Not Achieve ACA Goals

A Report to the
Governor
and the
Legislature of
the State of
Hawai'i

Report No. 15-20
December 2015



THE AUDITOR
STATE OF HAWAII

Office of the Auditor

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THE AUDITOR

STATE OF HAWAII

Kekuanao'a Building

465 S. King Street, Room 500

Honolulu, Hawai'i 96813



Office of the Auditor
465 S. King Street
Rm. 500
Honolulu, HI 96813
Ph. (808) 587-0800

Jan K. Yamane
Acting State Auditor
State of Hawai'i

A primary goal of the ACA is to create a simple, real-time eligibility process that uses electronic data to ease the paperwork burden on applicants and state agencies while expediting determination.

Recommendations

Response

Prior Audits

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Audit of the Department of Human Services' KOLEA System

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\$155 Million KOLEA project does not achieve all ACA goals

Med-QUEST Division did not properly plan for or implement the ACA

Although the Department of Human Services was able to launch its Kauhale On-Line Eligibility Application (KOLEA) system on the federally-mandated deadline of October 1, 2013, this new IT application falls short of meeting the goals of the *2010 Patient Protection and Affordable Care Act* (ACA). Poor planning and lack of effective leadership at the division level exacerbated already tight time constraints for developing KOLEA and forced the KOLEA Project Team to develop the eligibility and enrollment process while designing KOLEA.

We found the department did not properly plan for or implement KOLEA. As a result, the department has been unable to achieve the ACA's goals of creating a simple, real-time eligibility and enrollment process that uses electronic data to ease the paperwork burden on applicants and state agencies while expediting an eligibility determination. In addition, the \$155 million IT eligibility and enrollment system neither incorporates all ACA requirements nor meets the Med-QUEST Division's business needs. For example, KOLEA does not perform electronic data matching to verify applicant's income, and staff report that KOLEA is difficult to use and error prone. Consequently, the State could be paying benefits for people who are not eligible or improperly denying coverage for those who are eligible.

Enterprise system does not yet support human services programs, but integration is in progress

The ACA requires states to expand their Medicaid enrollment systems to integrate new programs, rules, and functionalities, and be able to apply streamlined verification and eligibility processes to other federal and state health and human services programs. We found the department has begun work on a new enterprise-wide system to allow integration of its 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.

Agency response

The department, which requested this audit, appreciated most of our recommendations but disagreed with our two primary findings. Although it claimed our main findings are "incorrect," we note that the department agreed with all but one of our recommendations. Pursuant to our professional standards, audit recommendations flow logically from findings and conclusions and are directed at resolving the cause of identified deficiencies and findings.

The department contends KOLEA has achieved the ACA's goals and meets all of the requirements for a Medicaid eligibility determination system because, it says, KOLEA accepts online applications, is connected to the federal data hub to conduct online verifications, and determines eligibility in a timely and accurate manner as confirmed by CMS. We found that KOLEA cannot access quarterly wage data from Hawai'i's Department of Labor and Industrial Relations, self-employment income, or unearned income. We also found that administrative efficiencies and reduced paperwork—primary goals of the ACA—have not been realized, according to eligibility workers, supervisors, and branch management.

The department also claims there is no ACA requirement that other human services programs be included in the streamlined eligibility system. Although the ACA does not require they be included, it does require states to facilitate enrollment in health and human services programs. *Human services programs* includes the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Low Income Home Energy Assistance Program, Supplemental Security Income, Child Care and Development Fund, and similar programs.

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Submitted by

THE AUDITOR
STATE OF HAWAI'I

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Foreword

This is a report on our audit of the Department of Human Services' (DHS) online Medicaid eligibility application, the Kauhale On-Line Eligibility Assistance (KOLEA) application. We conducted the audit pursuant to Section 131 of Act 119, Session Laws of Hawai'i 2015, which required the Auditor to perform a management and financial audit of KOLEA, including an evaluation of the procurement of KOLEA and the proposed addition of other DHS program functions such as the Supplemental Nutrition Assistance Program and the Temporary Assistance For Needy Families program, all contract modifications, planning for ongoing maintenance and operations for KOLEA, effectiveness of staff training on and utilization of KOLEA, and an analysis of KOLEA's current capabilities.

We wish to express our appreciation for the cooperation and assistance extended by staff of the Department of Human Services and other organizations and individuals whom we contacted during the course of our audit.

Jan K. Yamane
Acting State Auditor

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Chapter 1

Introduction

Section 131 of Act 119, Session Laws of Hawai‘i (SLH) 2015, required the Auditor to conduct a management and financial audit of the Department of Human Services’ (DHS) Kauhale On-Line Eligibility Assistance (KOLEA) system. The act asked that the audit include an evaluation of the procurement of KOLEA and the proposed addition of other DHS program functions, such as supplemental nutrition assistance program (SNAP) and temporary assistance for needy families (TANF), all contract modifications, planning for ongoing maintenance and operations for KOLEA, effectiveness of staff training on and utilization of KOLEA, and an analysis of KOLEA’s current capabilities. This report responds to that request.

Background

In 2013, the Hawai‘i’s Department of Human Services’ Med-QUEST Division implemented the KOLEA system application, which upgraded Hawai‘i’s Medicaid system by allowing individuals to apply for benefits online. KOLEA was implemented in nine months to meet the aggressive timelines imposed by the federal *2010 Patient Protection and Affordable Care Act* (commonly known as the ACA).

Medicaid

Created by Congress in 1965 under Title XIX of the Social Security Act, Medicaid is a federal/state entitlement program that pays for medical assistance for low-income individuals and families. Within broad national guidelines established by federal statutes, regulations, and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. In fiscal year 2013, net outlays for the Medicaid program nationwide were an estimated \$476.5 billion. With implementation of the ACA, total Medicaid program expenditures are projected to reach \$685.9 billion by FY2019.

The Centers for Medicare and Medicaid Services (CMS), a division within the U.S. Department of Health and Human Services (DHHS), administers Medicaid in partnership with states. Medicaid is not a direct provider of health care. States contract with and pay providers—such as hospitals, managed care plans, nursing homes, and physicians—to deliver Medicaid services at state-determined rates. CMS establishes policies for program eligibility and benefit coverage, matches state expenditures with funds for Medicaid, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse.

Affordable Care Act

Beginning in 2014, the *Affordable Care Act* expanded Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines. In addition to the higher level of allowable income, the ACA expanded eligibility to people under age 65 who were ineligible for Medicaid under prior law, but who are less than 18 years old, disabled, pregnant, or parents of eligible children. The ACA also modified how income is calculated for most Medicaid applicants, including those in the new eligibility group. Starting in 2014, states began using a modified adjusted gross income (MAGI) for eligibility determination for most applicants, a method that eliminates income resource tests. The combined effect of requiring coverage for up to 133 percent of the federal poverty level plus using MAGI-based budgeting effectively raises the income threshold for most Medicaid applicants to 138 percent of the federal poverty level.

States that implemented Medicaid expansion have experienced increased gains in enrollment since October 2013, when the initial enrollment period began. Following implementation of the ACA provisions and MAGI-based methodology on October 1, 2013, Hawai'i's Medicaid enrollment increased by 11 percent, from 292,423 in June 2013 to 325,510 in June 2014. As of June 2015, total Medicaid enrollment in Hawai'i was 332,197, a 2 percent increase from the prior year. Exhibit 1.1 shows Hawai'i's Medicaid enrollment for June 2013 through June 2015.

Exhibit 1.1**Hawai'i Medicaid Enrollment, June 2013 to June 2015**

Island	June 2013	June 2014	June 2015
O'ahu	179,227	199,062	201,668
Hawai'i	62,145	69,081	69,975
Maui	30,951	34,896	36,597
Kaua'i	16,072	18,255	19,661
Molokai	3,305	3,462	3,521
Lāna'i	723	754	775
Statewide	292,423	325,510	332,197

Source: Department of Human Services, Med-QUEST Division

In addition, the ACA required a coordinated and simplified application process between Medicaid and states' health insurance exchanges to allow consumers to apply for coverage with one application. A primary goal of the ACA is 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 an eligibility determination. For most states, this required new or greatly enhanced Medicaid enrollment information technology (IT) systems.

Enhanced federal funding for IT modernization

In April 2011, CMS began providing increased federal financial support for states that needed to overhaul their IT systems to implement the Medicaid changes required by the ACA. CMS offered states a 90 percent funding match (known as “90/10”) for the design, development, and installation or enhancement of Medicaid eligibility determination systems until December 31, 2015, and a 75 percent funding match for maintenance and operations of those systems beyond 2015 in certain circumstances. Prior to 2011, states could only receive a 50 percent funding match for their Medicaid eligibility IT systems.

Improvements to Medicaid eligibility IT systems included states undertaking efforts to implement the “no wrong door” policy. Under this policy, individuals can apply for health coverage through a state’s health care exchange or its Medicaid agency; regardless of which “door” they choose, their eligibility is to be determined for coverage under Medicaid, the Children’s Health Insurance Program (CHIP), or the health insurance exchange, including any income-based subsidies available through the health exchange. Applications are then routed to the program(s) for which the individual is eligible. Along with the “no wrong door” policy, CMS envisioned streamlined enrollment processes that include a real-time transfer of applications between states’ Medicaid agencies and their health insurance exchanges.

To qualify for 90/10 funding, states’ Medicaid IT systems were required to meet seven standards and conditions. The systems must be (1) modular; (2) advance the Medicaid Information Technology Architecture principle; (3) meet specified industry standards; (4) promote the sharing, leverage, and reuse of Medicaid technologies of systems within and among states; (5) support business results; (6) meet program reporting; and (7) ensure seamless coordination and integration with a state’s health insurance exchange and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services. In addition, systems must support a single streamlined application for coverage among insurance affordability programs; MAGI-based eligibility determinations; and new renewal processes and connections for electronic verifications.

KOLEA

The KOLEA project is a multi-year initiative to replace the Department of Human Services’ Hawai’i Automated Welfare Information System (HAWI), which was used by the department to support the eligibility determination process for medical, financial, and supplemental nutrition assistance programs. HAWI has been in existence for more than 20 years, and its technology could not support the mandatory provisions of the ACA, which had to be implemented by October 1, 2013.

Resources for KOLEA were provided by the 90/10 percent (federal/state) match through CMS. The system is designed to accept applications, conduct electronic verifications whenever possible, automatically determine eligibility whenever possible, and support other eligibility functions. According to the department, KOLEA's functions were initially to include:

- Processing applications for the State's insurance affordability programs, including applications for Medicaid, CHIP, and insurance for the Hawai'i Health Connector;
- Determining eligibility for the State's insurance affordability programs, including screening, intake, submittal, verification, and determination;
- Calculating subsidy and tax credits for commercial insurance coverage offered through the Hawai'i Health Connector;
- Providing complete case management capabilities to support Medicaid and other medical assistance services provided by DHS;
- Supporting plan enrollment of individuals and families through seamless coordination and integration with the Connector;
- Implementing a new interactive voice response system available to beneficiaries, the Med-QUEST Division's call center, and potentially, the Connector's call center; and
- Serving as a data warehouse to store data and support program administration related to eligibility and enrollment for the State's medical assistance programs.

Contract with KPMG, LLP

Through a request for proposals (RFP) process, DHS selected the firm KPMG, LLP, to develop, implement, and maintain an integrated eligibility solution, subsequently known as KOLEA. The initial award was protested by the non-selected offeror, but on December 14, 2012, the award to KPMG was affirmed. The non-selected offeror chose not to appeal the decision, and on January 11, 2013, CMS approved the contract, clearing the way for KPMG to begin work on the KOLEA project. Despite the one-month delay in the project start date, DHS launched the new online Medicaid eligibility system on October 1, 2013, in accordance with the ACA.

There have been nine modifications to the KPMG contract, increasing the total contract price from \$89.9 million to \$146.5 million. One amendment was for no-cost administrative modifications, one was to develop the State Data Hub for the Office of Information Management and Technology, five related to integrating with the Hawai'i Health Insurance Exchange, one was to add a document imaging function after the department learned that another division's system could not support KOLEA, and one involved exercising an option for additional services agreed to in the original proposal. Exhibit 1.2 summarizes the KPMG contract and its modifications.

Exhibit 1.2 Summary of KPMG Contract Modifications, January 11, 2013 to December 8, 2014

Date	Item	Description	Amount
1/11/2013	DHS-13-MQD-790	Implement an integrated eligibility system for DHS Med-QUEST Division	\$ 89,941,995
4/11/2013	Supplement 1	Administrative modifications	\$ -
6/28/2013	Supplement 2	Add State Data Hub for Office of Information Management Technology (option included in original contract)	\$ 8,592,750
6/28/2013	Supplement 3	Study to integrate KOLEA and the Hawai'i Health Insurance Exchange	\$ 1,000,000
7/12/2013	Supplement 4	"B-Prime Transition" changes to integrate KOLEA and the Hawai'i Health Insurance Exchange	\$ 1,107,400
12/4/2013	Supplement 5	Modify State Data Hub for "B-Prime Transition"	\$ (940,710)
12/17/2013	Supplement 6	Add Enterprise Content Management (another division's system could not fully meet the Med-QUEST Division's document imaging needs)	\$ 14,721,945
5/15/2014	Supplement 7	Add Customer Relationship Manager (originally intended as a shared Hawai'i Health Connector function, it was not delivered to DHS)	\$ 30,377,288
9/5/2014	Supplement 8	Allow the Connector to make initial eligibility determinations	\$ 1,905,000
12/8/2014	Supplement 9	Allow DHS to make initial eligibility determinations	\$ (210,000)
		Total Award	\$ 146,495,668

Note: Supplements 5 and 9 resulted in a net reduction to the contract cost.

Source: Department of Human Services

In addition to KPMG, three other vendors were awarded contracts for developing and supporting KOLEA. Public Consulting Group (PCG) was awarded a contract for \$7.8 million; SH Consulting, LLC for \$470,000; and IBM for \$4,837, bringing the total cost of KOLEA to \$154.7 million.

Integration with the Hawai‘i Health Connector

Given the federal mandate to integrate functions between state Medicaid agencies and health insurance exchanges, DHS and the Hawai‘i Health Connector were required to share and coordinate functionality. DHS and the Connector entered into a Memorandum of Agreement (MOA) to share technology, processes, and services wherever possible. This approach was to reduce administrative costs and help ensure a smooth transition for individuals applying for assistance or changing eligibility status. Pursuant to the agreement, DHS was to process applications for medical assistance and determine eligibility for Medicaid, advance premium tax credits, and cost share reductions for people purchasing individual insurance from the Connector. The Connector was to provide the enrollment function and allow Medicaid-eligible people to select a plan following eligibility approval. However, the interface between KOLEA and the Connector never materialized. Each side blamed the other for this failure.

In 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 June 2015, the State decided to transfer Hawai‘i’s online marketplace to the federal exchange. As a result, DHS has been tasked with building new interfaces for the additional functionality required for the federal health insurance exchange. KPMG was awarded a \$26 million non-bid contract to develop this interface, which was required to be in place by the enrollment period starting on November 1, 2015.

Other federal assistance programs

Act 119, SLH 2015, asked that our audit include DHS’s proposed addition of other programs, such as the supplemental nutrition assistance and the temporary assistance for needy families programs. Both programs are administered by DHS’ Benefit, Employment and Support Services Division (BESSD).

SNAP

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) is the largest domestic food and nutrition assistance program for low-income Americans. To receive benefits, households must qualify based on their income, expenses, and assets. Households with lower income receive higher benefits, up to a specified maximum. The program is administered by the U.S. Department of Agriculture’s Food and Nutrition Service. Federal regulations define eligibility requirements, benefit levels, and administrative rules, which are uniform across the nation (with a few exceptions). States are responsible for day-to-day operations of the program and for determining eligibility, calculating benefits, and issuing benefits to participants

according to federal rules. In FY2014, SNAP assisted 98,440 Hawai‘i families (an estimated 193,565 residents) with \$521 million in food stamp benefits.

TANF

The Temporary Assistance for Needy Families (TANF) program is one of the nation’s primary economic security and stability programs for low-income families with children. TANF, a federal block grant that provides \$16.6 billion annually to states and territories, is administered by the U.S. DHHS’ Office of Family Assistance. TANF funds are used to provide income support to low-income families with children, as well as to provide a wide range of services (for example, work-related activities, child care, and refundable tax credits) designed to accomplish the program’s four broad purposes. The goal of the program is to provide a safety net for families when they cannot work or are under-employed, help parents find and maintain employment, and help families achieve self-sufficiency. In FY2014, the average number of families receiving assistance in Hawai‘i was 8,927 (25,694 individuals). Total TANF benefits for the same period exceeded \$58.8 million.

DHS’ organization relevant to KOLEA

The department’s mission is to provide timely, efficient, and effective programs and to provide services and benefits to empower the most vulnerable to expand their capacity for self-sufficiency, self-determination, independence, healthy choices, quality of life, and personal dignity. In FY2014, the department’s operating budget was over \$2.8 billion, the State’s largest.

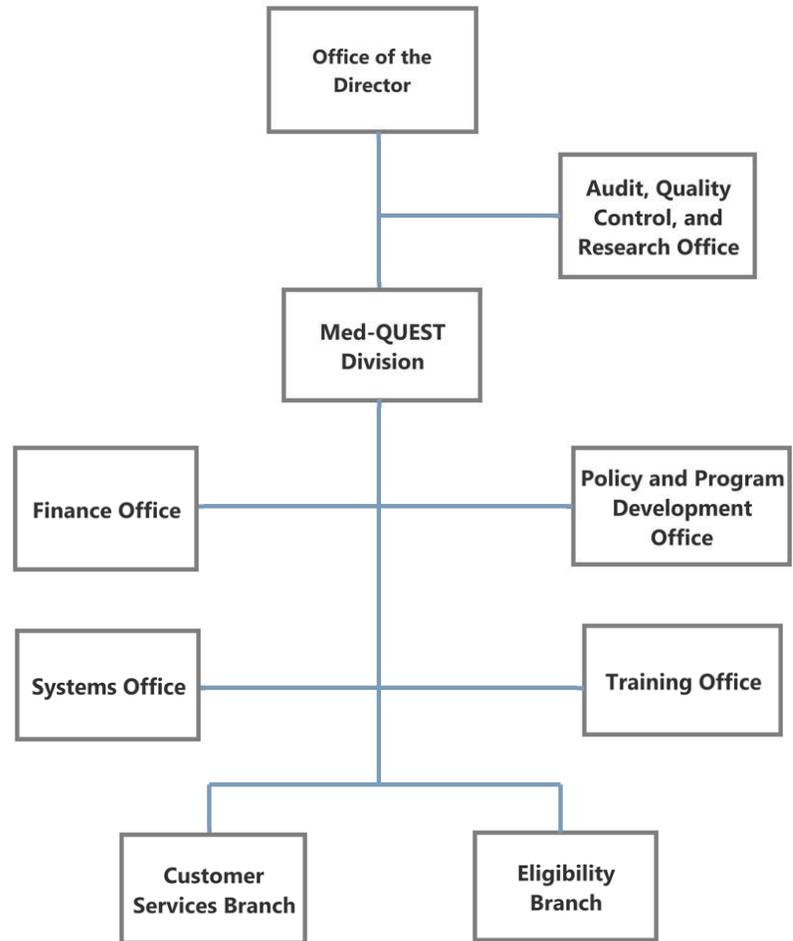
The department is headed by its director, who is supported by six offices and four divisions. The **Audit, Quality Control, and Research Office** implements quality control review systems for Medicaid as required by the federal Department of Health and Human Services, including conducting full verification and documentation of facts to establish eligibility of Medicaid program recipients.

The **Med-QUEST Division** administers the State’s Medicaid and other health insurance programs and provides health insurance to low-income families, children, and individuals. This division was largely responsible for KOLEA’s planning and implementation.

The division is supported by five offices, four of which are involved with KOLEA. The **Finance Office** coordinates, manages, and monitors fiscal activity, including procurement and contract evaluation. The **Systems Office**, which manages and coordinates the division’s information systems, coordinates KOLEA system changes by explaining the department’s business needs to the vendor and testing the vendor’s

solution. The **Policy and Program Development Office** is responsible for providing support and assistance to the division in developing and maintaining the division's program policies, and develops procedures related to the department's programs, including research, preparing state plan amendments, waiver development and renewal activities, administrative rule changes, and policy directives. The office also coordinates monitoring applicable federal and state law changes related to health care programs and develops and implements departmental programs. The **Training Office** develops and coordinates training activities and opportunities for division staff related to the department's programs.

The division is also supported by three branches, two of which have primary involvement with KOLEA. The **Customer Services Branch** enrolls, dis-enrolls, and registers eligible people into the department's health care delivery programs. The **Eligibility Branch** is responsible for the statewide eligibility determination process related to the department's health care and health insurance programs. Exhibit 1.3 illustrates the department's division, offices, and branches that are involved with KOLEA.

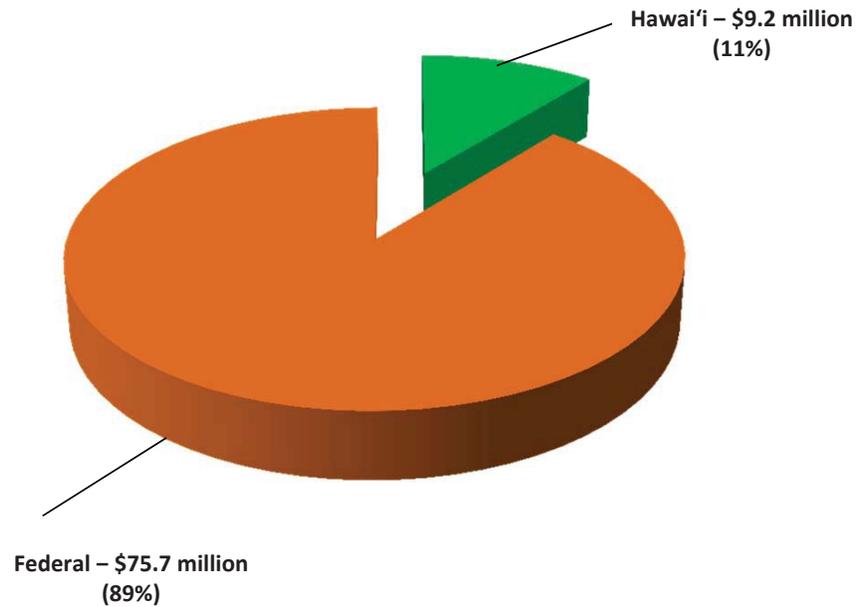
Exhibit 1.3**DHS Organizational Chart of Division, Offices, and Branches Relevant to KOLEA**

Source: Department of Human Services

Funding for KOLEA

In FY2014, expenditures for KOLEA totaled \$52.3 million (2 percent of the total DHS budget). The Med-QUEST Division received a 90 percent federal funds match to design, develop, and install or enhance a Medicaid eligibility IT system, and is receiving a 75 percent match to maintain and operate the upgraded system. Exhibit 1.4 illustrates the federal/state expenditure split for KOLEA.

**Exhibit 1.4
Federal/State Expenditure Split for KOLEA as of
September 30, 2014**



Source: Office of the Auditor

Exhibit 1.5 details federal and state expenditures for KOLEA as of September 30, 2014.

**Exhibit 1.5
Details of KOLEA Expenditures as of September 30, 2014**

	Federal	State	Total
Design, development, and installation (90/10 funding)	\$72,190,488	\$8,021,165	\$80,211,653
Maintenance and operations (75/25 funding)	3,553,331	1,184,443	4,737,774
Total KOLEA expenditures	\$75,743,819	\$9,205,608	\$84,949,427

Source: U.S. Government Accountability Office

Through September 30, 2014, Hawai'i spent nearly \$85 million to replace and operate its Medicaid eligibility IT system. Of this, \$80 million was to replace the old system (HAWI); the remaining \$5 million was for maintenance costs. Most of the \$85 million was paid to contractors to perform the work.

Prior Audits

We have conducted eight prior audits of the Department of Human Services' QUEST-related programs and its IT systems. Our 1996 *Audit of the QUEST Demonstration Project* (Report No. 96-19) reported that Phase I of the project was inadequately planned and hastily implemented; lacked management controls, staff, and a required management information system (MIS) to properly administer the program; and had yet to demonstrate it was saving the State money. We also expressed concern that the federal government might require the State to revert to the traditional Medicaid program because it had not met requirements of the Health Care Financing Administration.

Our 1997 *Management Audit of the Department of Human Services* (Report No. 97-18) found that controls for QUEST eligibility determination had not significantly improved, annual eligibility verification processes were still weak and had substantive backlogs, the required MIS was still undeveloped, and the department lacked an effective evaluation mechanism for QUEST. After three years, QUEST's federally required encounter data had not been analyzed, and the required quarterly reports had not been submitted.

Our 1998 *Financial Audit of the Department of Human Services* (Report No. 98-14) found continued internal control and operational problems that affected the Med-QUEST Division and the QUEST Demonstration Project. Annual re-verification requirements had not been met, more than \$5 million in clients' share of QUEST premium costs were uncollected, and the Hawai'i Automated Welfare Information (HAWI) System lacked adequate data entry controls, resulting in overpayments.

Our 2001 *Audit of the Department of Human Services' Information Systems* (Report No. 01-05) found that the department's failure to follow state information systems planning guidelines hindered its ability to recognize and plan for more effective information systems. This resulted in inadequate linkages among computer systems and ineffective sharing of information. Several intervening manual tasks were required to retrieve information from other systems, reducing effectiveness of the department's computer systems and hindering operational efficiency. We also found that the department's major computer systems did not effectively share information, resulting in duplicate data entry and increased data inaccuracies, and the department missed the opportunity to finance upgrading the computer system's functionality with enhanced federal dollars.

Also in 2001, our *Financial Audit of the Med-QUEST Division of the Department of Human Services* (Report No. 01-10) continued to find poor management control practices within the QUEST Demonstration Project. Program files lacked required documentation, certifications, and

evidence of supervisory review. The backlog of eligibility applications had not been resolved. The division continued to be inconsistent in collection of reimbursements and dis-enrolling those who failed to pay required co-payments. And the division's oversight of capitation reconciliations had diminished following the transfer of reconciliation responsibility to the health plans.

Our 2003 *Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project* (Report No. 03-07) found that QUEST continued to experience problems from inadequate planning and design that hampered the development and expansion of a managed care approach to healthcare. Changes in Medicaid expenditures, provider participation, and temporary lifting of the enrollment cap placed the program in a budget shortfall and raised concerns about its ability to continue to keep costs under control. Self-declaration and presumptive eligibility practices reduced the application backlog but also increased the likelihood that ineligible applicants might receive benefits. Finally, after six years, a management information system was implemented.

Our 2004 *Audit of the Department of Human Services' Expedited Application Process for Pregnant Women* (Report No. 04-12) found that despite making notable improvements in processing applications for pregnant women, the division fell short of its self-imposed expedited application process standard that it would process 95 percent of completed applications from pregnant women within five business days. In addition, statistics maintained by division staff could not be reconciled with the division's computer database, which caused the division to rely on skewed figures in making its assertions of compliance with the five-day standard.

Finally, our 2014 *Audit of the Department of Human Services' Med-QUEST Division and Its Medicaid Program* (Report No. 14-02) found that although the division was generally responsive to legislative information requests, the program and cost data it provided did not fulfill legislative needs. We found that in 2004, the department instituted a "passive renewal" policy in which Medicaid beneficiaries were automatically deemed eligible for annual renewal of coverage regardless of whether or not they signed and returned a completed form indicating that their eligibility status had not changed. The division's internal review projected an annual loss of \$19.6 million resulting from such passive renewal cases. We also found the State was exposed to tens of millions of dollars in losses due to Medicaid fraud, waste, and abuse. In its response to that report, the department said that its new eligibility system, KOLEA, would reduce such eligibility errors.

Objectives of the Audit

1. Assess whether the Department of Human Services adequately managed its resources to effectively implement the Kauhale On-Line Eligibility Assistance system.
2. Assess the adequacy of KOLEA in supporting the goals of the *2010 Patient Protection and Affordable Care Act (ACA)* and meeting public welfare needs.
3. Make recommendations as appropriate.

Scope and Methodology

We conducted interviews with key program staff, employees, contractors, and legislators, and reviewed relevant documents. We evaluated DHS' Med-QUEST Division's planning and implementation of KOLEA in fiscal years 2011 to 2013 by reviewing the process it used to identify its business needs and ACA eligibility and enrollment requirements, and by assessing selected KOLEA functions related to Medicaid eligibility determination and verification. We also analyzed statistics on applications and renewals processed and data the division reports to management. To assess KOLEA's performance in supporting DHS' goals and meeting public welfare needs, we reviewed the department's planning and efforts for the integration of other human services programs.

Section 131 of Act 119, SLH 2015, also asked us to evaluate the procurement of the KOLEA system and all contract modifications. We therefore reviewed the department's procurement processes, including its issuance of RFPs, bid awarding, contract modifications, and monitoring of deliverables. We reviewed the nine modifications to the KPMG contract and the department's contract for independent verification and validation (IV & V) services. Because we found that the division submitted an incomplete and flawed RFP for the bid, we shifted our audit focus to the division's planning and preparation of the RFP.

Our work was performed from May 2015 through October 2015 and conducted in accordance with the Office of the Auditor's *Manual of Guides* and generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence we obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Chapter 2

\$155 Million KOLEA Project Does Not Achieve All ACA Goals

The *Affordable Care Act* (ACA) envisions a streamlined, simplified, and coordinated system for health subsidy programs (including Medicaid, the Children’s Health Insurance Program, and exchange-based premium and cost-sharing subsidies) that determines eligibility, enrolls individuals, facilitates seamless transitions between programs, and allows for electronic rather than paper-based self-service enrollment and renewal. In 2011, the federal government began providing a time-limited, 90 percent federal match for states to upgrade or replace their aging Medicaid eligibility and enrollment systems in preparation for new data-driven enrollment processes under the ACA. Hawai‘i took advantage of this enhanced funding opportunity to replace its 25-year-old Hawai‘i Automated Welfare Information System (HAWI).

Although the Department of Human Services (DHS) was able to launch its Kauhale On-Line Eligibility Assistance (KOLEA) system on the ACA-mandated deadline of October 1, 2013, this new information technology (IT) system falls short of meeting the ACA’s goals. Poor planning and lack of effective leadership at the division level exacerbated already tight time constraints for developing the system and forced the KOLEA Project Team to develop the eligibility and enrollment process while designing KOLEA. The result is the \$155 million IT eligibility and enrollment system neither incorporates all ACA requirements nor meets the Med-QUEST Division’s business needs. For example, KOLEA does not perform electronic data matching to verify applicant’s income. In addition, staff report that KOLEA is difficult to use and is error prone. The end result is that the State could be paying benefits for people who are not eligible for them or improperly denying coverage to those who are eligible.

Summary of Findings

1. The Department of Human Services did not properly plan for or implement the KOLEA system. As a result, the department cannot achieve all the goals of the federal *Affordable Care Act*—namely, 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 department's enterprise 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.

Med-QUEST Division Did Not Properly Plan For or Implement the ACA

The Med-QUEST Division unsuccessfully planned for the implementation of its new, \$155 million Medicaid eligibility IT system. Already faced with a short time frame, the KOLEA project team's challenges in designing and implementing the system were compounded by the former division administrator's reluctance to start planning for the ACA changes early on and his failure to intervene when staff who were responsible for developing new policies and procedures shunned their duties. As a result, KOLEA was designed to facilitate the existing Medicaid eligibility and enrollment process without fully complying with the new ACA requirements.

In addition, the division failed to adequately address how its Eligibility Branch workers, who have hands-on experience interacting with thousands of Medicaid applicants annually, would be affected by the ACA changes and what their roles would be in the new system. In addition, Eligibility Branch workers were not appropriately trained on either the new ACA eligibility rules, policies, and procedures or on how to navigate KOLEA and its subsequent system updates. This is a serious issue since users report that KOLEA produces inconsistent and inaccurate eligibility determinations, requiring eligibility workers to manually resolve them.

Further, the division inappropriately relied on the KOLEA project team, which was tasked with designing and implementing the new system, to understand the ACA's myriad new eligibility and enrollment provisions and incorporate them into KOLEA's software. The eligibility rules and accompanying policy recommendations were based on one team member's interpretation of the ACA—a complex law of at least 900 pages—and KOLEA software that was developed without division management's assurance that they would comply with the ACA. As a result, KOLEA cannot perform real-time electronic data matching for wages and unearned income as was envisioned by the ACA. Eligibility workers also find KOLEA difficult to use—there are now twice as many web pages, many of which are not intuitive or user-friendly screens, to navigate compared to the previous system.

Ineffective leadership and oversight by Med-QUEST administration led to botched implementation of the ACA

Successful implementation of a major IT change requires effective leadership from the top of an organization. However, we found that the former Med-QUEST Division administrator did not adequately lead the division to successfully implement the major changes required by the ACA. A division staffer described the former administrator as a “roadblock” to the project.

The division could have begun planning for the impending ACA changes several years before they took effect. However, we found that the division’s former administrator refused to allow planning to begin until late 2011, thereby shortening an already tight schedule for implementing such major changes. The former administrator also failed to ensure the division’s policy office performed its duties to appropriately prepare the division for the ACA’s implementation. Lack of leadership from its former administrator allowed the Med-QUEST Division to build the KOLEA system before it developed a comprehensive eligibility and enrollment process, which the IT system was supposed to facilitate. The former administrator also did not ensure the division’s training office provided adequate training to eligibility workers regarding the new ACA requirements. We found that eligibility workers lack sufficient knowledge of ACA’s requirements to render accurate eligibility determinations.

Former Med-QUEST administrator’s delayed planning for ACA changes exacerbated time constraints

The ACA was enacted on March 23, 2010. Among other things, the act specified that effective January 1, 2014, eligibility for medical assistance was to be based on applicants’ modified adjusted gross income (MAGI), rather than on income deductions as it had been previously. Almost a year later, in April 2011, the federal government announced the availability of increased (90/10) funding for states to upgrade their Medicaid systems. Thus, the department—and the Med-QUEST Division specifically—knew years in advance that significant changes to Hawai‘i’s Medicaid eligibility process would be required and that additional federal funding would be available to do so.

Despite advanced warning of the impending changes, the division did not start planning the upgrade of its eligibility system (what became KOLEA) until late 2011, when the project team began work and the division issued a request for proposals (RFP) for Eligibility System Consultant Services. According to an eligibility program specialist in the division’s Policy and Program Development Office, beginning in 2010, various Med-QUEST division branch administrators and staff officers asked the former division administrator to assemble a planning group in preparation for the soon to be released ACA requirements. The specialist told us the former administrator was reluctant to do so because there was

not a lot of useful information about the coming changes at the time and that only after months of pressuring did the former administrator agree to sanction the planning group. The specialist described the former administrator as the project's "first roadblock," who lacked the foresight to start the KOLEA planning even when others were pressuring him to begin early.

The division could have used the time between April 2011 and December 2011 to, among other things, define its policies and processes and ensure that people with the right skills were appointed to key roles in the ACA implementation efforts. The division administrator's lack of foresight caused unnecessary delay in planning for the ACA changes, further shrinking the time available for the division to roll out its new eligibility system (KOLEA)—a massive IT undertaking—from 27 months to a mere 18 months.

Policy office was allowed to shirk its responsibility to ensure policy recommendations and eligibility and enrollment procedures were made ahead of the ACA changes

At the direction of the department's director and the Med-QUEST Division administrator, the division's Policy and Program Development Office is responsible for establishing and communicating Medicaid policies and procedures to the division. However, we found no evidence that the former division administrator exercised sufficient leadership or control over the policy office. Failure to hold the policy office accountable for its core duties meant that the division's Eligibility Branch struggled to decipher the new Hawai'i Administrative Rules (HAR) and the KOLEA project team was left on its own to develop new eligibility rules and policies for KOLEA in line with the new ACA requirements.

For example, the KOLEA project team was responsible for developing KOLEA's Verification Plan, a federally required document that describes policies and procedures for corroborating applicant statements about income and other eligibility criteria. The Verification Plan should incorporate both the ACA's requirements and corresponding HAR, which have the force and effect of law. However, we found a number of discrepancies between the Verification Plan and the administrative rules. For instance, the Verification Plan does not require using IRS data and state-administered supplementary payment programs for verifying income, including data age, and security requirements and the absence of electronic file matches. But Hawai'i rules require using these sources for income verification. Exhibit 2.1 lists discrepancies between the administrative rules and the department's Verification Plan.

Exhibit 2.1

Discrepancies Between Hawai'i Administrative Rules and DHS' Verification Plan

Hawai'i Administrative Rule	DHS Verification Plan
<p>Section 17.1714.1-39 (1), HAR, requires verification of financial information from sources that include:</p> <ul style="list-style-type: none"> • Internal Revenue Service • State Administered Supplementary Payment Program 	<ul style="list-style-type: none"> • The state decided not to use IRS data because the data is old and security requirements are too onerous • Electronic file match currently does not exist
<p>Section 17.1714.1-39 (2), HAR, requires use of information related to eligibility or enrollment from:</p> <ul style="list-style-type: none"> • Supplemental Nutrition Assistance Program • Temporary Assistance for Needy Families (Title IV-A of federal <i>Social Security Act</i>) 	<ul style="list-style-type: none"> • Electronic file match currently does not exist • Electronic file match currently does not exist

Source: Office of the Auditor

According to the policy office's acting Medical Assistance Program officer, the Verification Plan does not match the administrative rules because they were both developed at a time when the policy office was inundated with work. During this time, the policy office had to update the department's federal Section 1115 waiver, amend the state's Medicaid Plan, and make amendments to the Hawai'i Administrative Rules as a result of the ACA and changes to the corresponding federal rules. At the time of our audit work, the discrepancies between Hawai'i's administrative rules and the department's Verification Plan had yet to be rectified, though there were plans to do so. Nevertheless, for reasons we were unable to determine, the former division administrator did not hold the then-head of the policy office accountable for performing its key responsibilities to establish eligibility and enrollment policies and procedures ahead of the ACA implementation.

Achieving ACA's goals entails more than just upgrading Medicaid IT systems. Policy and procedural decisions need to be embedded into the new systems, and some tasks that had previously been performed manually will become automated. This requires state agencies to identify areas where processes can be improved or automated. Agencies must examine what is in place, find the duplications and bottlenecks, remove policies and procedures that add no value or are not required by law, and reassess and refine the results. Agencies should also have a structured process to transition staff and resources to their future roles

to ensure they can meet the agency's new needs. Such tasks are the responsibility of the policy office: its staff are in charge of developing and maintaining the division's policies and procedures related to eligibility requirements in accordance with state and federal laws, and with issuing guidance to division staff on how to implement policy changes.

However, the policy office failed to establish a new eligibility and enrollment process that envisioned eligibility workers' new roles under the ACA. Policy staff were never instructed to establish a new process and procedures for Medicaid eligibility determinations and enrollment; the former Medical Assistance Program officer did not feel that the policy office was responsible for developing procedures to implement the new administrative rules pursuant to the ACA. The division's policy office provided Eligibility Branch workers with little to no policy and procedures documentary guidance on how to apply the new ACA eligibility requirements. It is unclear why the former division administrator did not require the head of the policy office to perform these critical functions.

Training Office failed to ensure eligibility workers were properly trained on new ACA requirements

The former division administrator also did not ensure that the division's training office provided sufficient training to its Eligibility Branch workers regarding the impending ACA changes. Even new, highly automated eligibility systems require Eligibility Branch workers to perform eligibility determinations and manage the more complex cases. Therefore, it is essential they receive training on operating the new IT systems, what the new eligibility rules are, and any changes to the division's processes.

KPMG, the contractor that designed KOLEA, was required to provide technical training for all KOLEA departmental users; however, training on the department's policies and procedures in relation to the new ACA requirements was outside KPMG's scope of responsibility. According to the division's assistant administrator, the training office could not train eligibility staff adequately, in part due to turnover and other staffing issues as well as their own lack of knowledge of how KOLEA works. These issues should have been addressed by the division administrator.

The training that Eligibility Branch staff did receive was inadequate and left them without a working knowledge of the new eligibility requirements or how to use KOLEA. For instance, their training on MAGI and the new eligibility requirements consisted of a general overview of policy changes. They did not receive detailed instruction on procedures for implementing the new policies, and were told that aside

from some tax-related differences, eligibility and enrollment policies and procedures were unchanged. Furthermore, initial training sessions on how to use KOLEA provided by KPMG occurred before KOLEA was completed. As system enhancements were done to KOLEA, Eligibility Branch staff received desk references and work-around procedures, but no additional training; and the information they did receive was not timely. According to an Eligibility Branch administrator, one of the biggest problems the branch faces is that Eligibility Branch staff do not understand and properly use KOLEA.

We found that Eligibility Branch workers generally lack a sufficient understanding of MAGI-based eligibility determination requirements and cannot consistently make correct eligibility decisions. Furthermore, the department's Audit, Quality Control, and Research Office staff told us that, in the absence of policy and procedure directives, they cannot verify whether eligibility determinations made by KOLEA and Eligibility Branch workers comply with federal and state requirements. This calls into question the training they received and the reliability of their eligibility determinations.

We also found that Eligibility Branch supervisors spend a lot of time training staff and answering staff questions—essentially functioning as an in-house help desk—rather than attending to management duties. However, there was no evidence that the supervisors have any greater understanding of MAGI-based eligibility rules than their workers. Therefore, we question the quality of information the policy office has communicated to Eligibility Branch supervisors regarding MAGI-based eligibility rules. Training is a vital component of any system's successful implementation and should be a priority if the division hopes to achieve KOLEA's desired results of streamlining and improving the state's Medicaid eligibility and enrollment process.

Med-QUEST management inappropriately relied on the KOLEA project team to implement the ACA's eligibility and enrollment provisions

The division's policy office was responsible for developing the division's policies and procedures. However, the former division administrator allowed the policy office to shirk this responsibility. Instead, the KOLEA project team developed its own recommendations for amending the division's Medicaid eligibility process, which were included in the RFP requirements for the KOLEA system.

As a result, rules that were built into KOLEA's software and the accompanying policy recommendations were based on a single person's interpretation of the 900-page ACA. Also, the project team designed KOLEA's eligibility and enrollment process before division management assured it would comply with the ACA. Best practices state that organizations should properly define their business needs by the results required; in this case, adherence to the new ACA eligibility rules.

Eligibility rules and policy recommendations were based on one team member's interpretation of the ACA

We found the division's policy office did not support the KOLEA project or its Project Team. However, the team included one of the policy office's Eligibility Program specialists, who was initially to act as a liaison between the policy office and the team. The team—and eventually the division—primarily relied on that specialist to interpret the ACA without substantive input from the policy office. The specialist's interpretation and recommendations for proposed changes to the administrative rules were used as the basis of the KOLEA RFP. There is significant risk in relying primarily on one person to interpret such significant changes as those found in the ACA.

The specialist was assigned to the KOLEA Project Team because her areas of expertise (which included children, pregnant women, adults, and parent caretaker relatives) were all affected by the ACA changes and made up a large portion of the eligibility and enrollment processes that KOLEA was to facilitate. The specialist admitted she did not review all of the ACA and its proposed rule changes. Instead, she performed a search for particular keywords (such as “eligibility” and “enrollment”) relevant to her areas of expertise and studied those sections to make recommendations for amendments to the administrative rules. Against the wishes of the then-head of the policy office, who had prohibited her staff from communicating with the KOLEA Project Team, the specialist consulted with two other policy office specialists regarding the eligibility and enrollment of Aged, Blind, and Disabled (ABD) groups. However, all other portions of the State's Medicaid eligibility and enrollment process remained unchanged.

We found that recommendations from the one Eligibility Program specialist and two other ABD policy office specialists provided the basis for the entire update of the division's Hawai'i Administrative Rules and its eligibility and enrollment process. The KOLEA Project Team used the Eligibility Program specialist's recommendations as the starting point to discuss eligibility requirements with other stakeholders, who included the former division administrator, the former head of the policy office, and the Eligibility Branch administrator. Although the policy office was supposed to sanction these recommendations, it provided only superficial feedback. In effect, the single Eligibility Program specialist was the only policy expert substantively involved in these discussions. Therefore, this lone specialist was chiefly responsible for the State's revised Medicaid eligibility and enrollment rules, policies, and procedures.

Project team designed KOLEA's eligibility and enrollment process ahead of management's assurance that it would comply with the ACA

Compounding the risk of allowing a single policy expert to drive the division's ACA-related policy and procedure changes, we found that division management did not properly vet the specialist's recommendations. Those recommendations focused on making the State's existing Medicaid eligibility program compliant with the new ACA requirements. However, the KOLEA project team did not receive input from the entire division. The KOLEA team's recommendations were not made with a comprehensive view of the State's entire Medicaid eligibility and enrollment program. Furthermore, those recommendations were included in the RFP requirements for the KOLEA system. Consequently, the division released an RFP, and subsequently awarded a contract, to build an IT system to facilitate a process that it had not yet fully defined.

This process left unchanged the sections of the State's eligibility and enrollment rules, policies, and procedures that were not identified in the project team's recommendations. The result was a patchwork of new and existing Medicaid eligibility rules, which became the framework upon which KOLEA was built.

The KOLEA Project Team's patchwork of rules, policies, and procedures were incorporated into the division's RFP for a technical system to facilitate a new eligibility and enrollment system. The division's policy office did have an opportunity to review the RFP before it was released, but the office provided non-substantive feedback. In order to meet the federally imposed deadlines, the project team released an RFP that was drafted without meaningful input from the eligibility system's other stakeholders.

Numerous defects may negate KOLEA's advancements

KOLEA was intended to accept and process Medicaid and CHIP applications, verify applicants' information electronically whenever possible, automatically determine eligibility, and support other eligibility functions such as sending notices. However, we found that KOLEA does not perform electronic data matching to verify applicants' income, as was envisioned by the ACA. The division's Eligibility Workers (the staff most impacted by KOLEA) find the new system difficult to use. Eligibility Branch staff now spend more time manually processing applications that KOLEA cannot and resolving KOLEA processing errors. We also found that the division does not measure the efficiency of its new eligibility process, and therefore cannot properly identify and correct existing weaknesses.

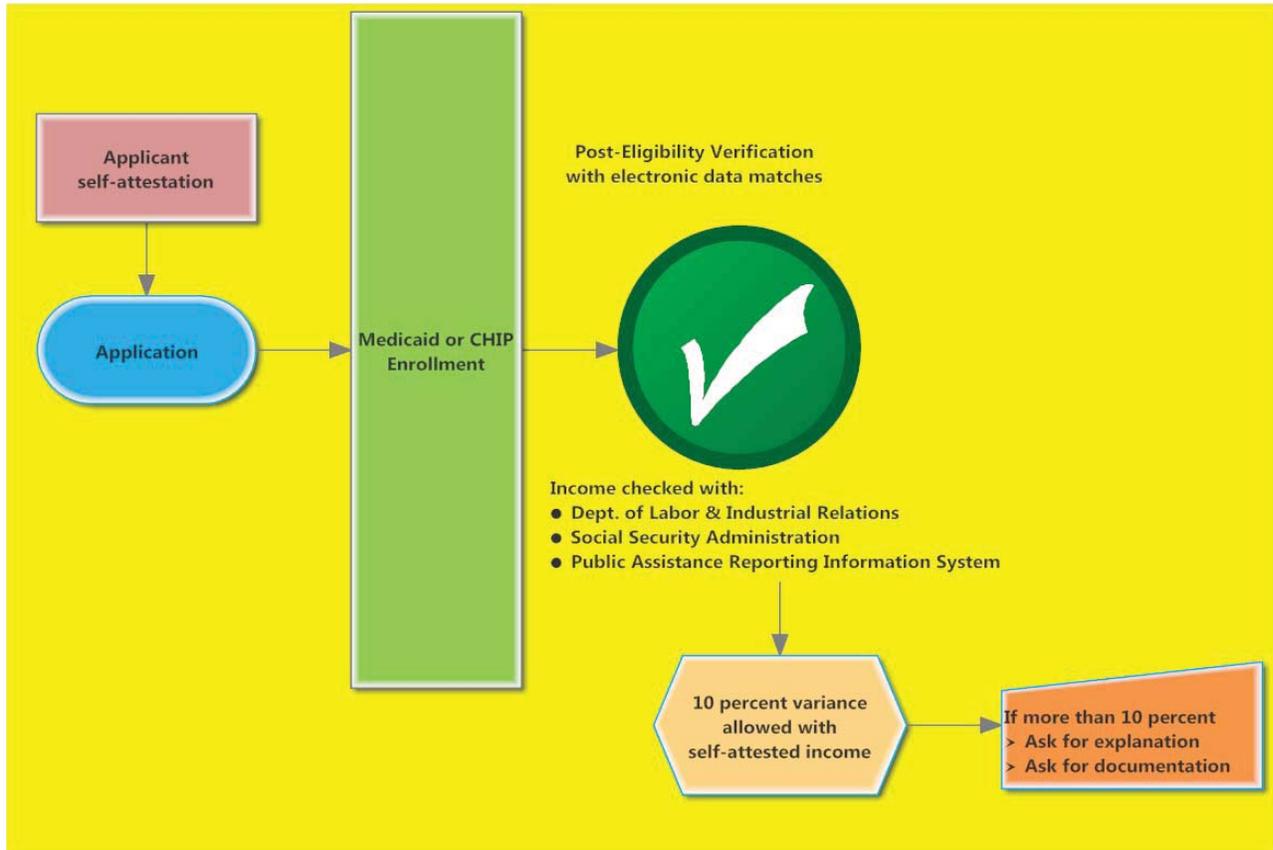
KOLEA does not perform electronic data matching to verify applicants' self-reported income, as was envisioned by the ACA

The ACA requires that states verify applicants' self-reported income to ensure they are eligible to receive Medicaid. The ACA envisioned verification would be done via electronic data-matching. A majority of states (39) conduct verification prior to enrolling applicants in such programs; Hawai'i is one of 11 states that verify income after an applicant is enrolled in a program. While post-eligibility verification is acceptable under the ACA, we found that the department has not established an interface with the Department of Labor and Industrial Relations (DLIR), which would allow for electronic confirmation of an applicant's self-reported income. As a result, Med-QUEST eligibility workers must manually verify some applicants' income, thereby increasing the risk of inaccurate eligibility determinations.

Hawai'i's Verification Plan calls for KOLEA to confirm applicants' income by electronically comparing their self-reported information with state and federal databases. KOLEA is intended to match an applicant's self-reported wage and other earned income with information from Hawai'i's DLIR, and to match other income with information from the federal Social Security Administration. KOLEA also uses the federal Public Assistance Reporting Information System (PARIS), which provides data on income received from the U.S. government, Department of Defense, and Department of Veterans Affairs, to assess whether applicants are receiving benefits in other states. Exhibit 2.2 illustrates Hawai'i's eligibility and enrollment process for modified adjusted gross income (MAGI)-based applicants.

Exhibit 2.2

Hawai'i Eligibility and Enrollment Process for MAGI-Based Applicants



Source: Office of the Auditor

However, we found that the department has not reached agreement with DLIR regarding sharing, using, safeguarding, and disclosing DLIR's data on wage income and unemployment insurance income; therefore, KOLEA cannot confirm applicants' income via DLIR databases. A program development officer at DLIR's Unemployment Insurance Division told us that prior to KOLEA's launch, the Office of Information Management and Technology led discussions to establish a real-time interface between DLIR's mainframe computer, KOLEA, and the Hawai'i Health Connector. The development officer told us DLIR rejected the proposal because of the breadth of DHS' data request and the inclusion of the Connector, which is not a government agency. However, she said that discussions between DLIR and DHS regarding an agreement for data matches in early 2015 and a memorandum of agreement for real-time matching is expected in early 2016.

We also found that the department has not been interfacing with the IRS, and therefore cannot confirm applicants' other income. In addition, we found that KOLEA lacks a way to electronically verify self-employment income.

KOLEA does not meet the automated eligibility system envisioned by the ACA because it does not perform electronic data matching for wage data. Instead, the division's eligibility workers must manually obtain DLIR wage data and verify whether some applicants meet or exceed allowable income levels. Eligibility Branch staff told us they have received DLIR quarterly income data "once or twice" since KOLEA's debut. KOLEA project staff told us they have provided DLIR quarterly income data to eligibility workers five times since October 2013. Although the department appears to be operating within the boundaries of its Verification Plan, the lack of electronic substantiation for financial information circumvents the intent of federal ACA regulations that income be corroborated via electronic data matches.

Eligibility workers find KOLEA difficult to use

Staff and administrators from the Eligibility Branch as well as staff from the Audit, Quality Control, and Research Office told us that KOLEA can accept online applications, process most applications received, verify certain information via electronic matches, automatically determine eligibility, process some renewals, and send notices as appropriate. However, they also reported numerous ongoing problems with KOLEA.

For example, eligibility workers said KOLEA is not always correct in how it captures, stores, or processes applicants' information used to make eligibility determinations. Branch administrators believe the way eligibility workers input data impacts whether KOLEA processes it correctly. Some do not trust KOLEA to determine eligibility properly and said they have to either use manual overrides to process applications or check determinations made by KOLEA for accuracy. Eligibility workers said they now spend more time manually processing applications and renewals that KOLEA cannot process, resolving processing errors and other issues, and assisting clients who are confused by notices sent to them. Exhibit 2.3 lists some of the more serious problems with KOLEA that eligibility staff reported.

Exhibit 2.3 KOLEA Problems Reported by Eligibility Branch Staff

1. Not capable of correctly processing complex coverage types, like long-term care and Medicaid spend down.
2. Sometimes generates inappropriate notices, such as notices with incorrect or missing information or notices requesting documentation to support information that has already been verified by an eligibility worker.
3. Defaults that would identify and eliminate application questions related to inapplicable eligibility criteria—for example, questions related to pregnant women for a male applicant—are not in place.
4. Different functions sometimes work one day but not the next, and the functionality issues vary from case to case.
5. Did not integrate with the Hawai'i Health Connector, the state's healthcare exchange marketplace system.

Source: Office of the Auditor based on Med-QUEST Division Eligibility Branch questionnaires and interviews

Some eligibility workers also said KOLEA is not user-friendly and is difficult to navigate. Although entering applications is easy, they said, checking and editing data is difficult and time consuming. When KOLEA flags applications as pending or in error, it does not clearly identify the reasons why. Eligibility workers must review the contents of KOLEA's electronic case files to determine what information is missing or action needed. This can be time-consuming because case files are displayed on multiple screens and tabs within screens, which must be checked one by one. Eligibility workers may need to search through 20 screens, compared to only ten screens in HAWI. The layout of KOLEA's numerous screens and tabs has also changed with each update, making it even more difficult for staff to know where to find and enter data. Adding to their frustration, the causes of processing errors seemingly vary from case to case, and eligibility workers often rely on trial and error to guess what a problem is and how to fix it to push an application through the system.

The result of KOLEA's flawed design and subsequent defects is that eligibility workers must perform additional steps to process applications, thereby diminishing the efficiencies gained by using KOLEA. The system defects can also result in improper eligibility determinations, improper benefit payments for individuals who are wrongly determined to be eligible, unnecessary delays for eligibility determinations and coverage start dates, incomplete or inaccurate case records, and failures to send appropriate notices to applicants and recipients.

In addition, we found that KOLEA does not create an adequate audit trail of historical applicant information and how that information was used to determine eligibility. Without access to the application information used to determine eligibility, quality control staff cannot verify the accuracy of the information or determine the propriety of an eligibility or denial determination. KOLEA can provide decision reports that show its eligibility determination logic and decision summaries that show the financial information used to calculate MAGI and determine eligibility, but quality control staff say these reports are not always available or complete.

The division does not measure the efficiency of its eligibility process, so it cannot correct problems

Officials and managers must have accurate, timely, and relevant information, along with the skills and knowledge to analyze this information to make improvements when needed. The division's assistant administrator recognizes that management is responsible for measuring the effectiveness of KOLEA by looking at various performance reports. Management's main source of information on the impact of the division's use and implementation of KOLEA is weekly and monthly eligibility and enrollment data submitted to the federal government (CMS). Management also monitors staff overtime and costs, expenditures and allotments, and position counts and vacancies.

We found that the information contained in these reports to CMS is insufficient. Management's performance indicators do not present a comprehensive picture of the division's eligibility and enrollment processes or measure the division's efforts to implement KOLEA and the eligibility and enrollment provisions of ACA. Examples of performance indicators that management does not monitor but which could help measure the impact of the division's efforts include:

- Number of applications manually input and processed;
- Number of cases/applications assigned to each worker;
- Reductions in the number of days between application and enrollment;
- Percentage of applications and renewals that need to staff time to process; and
- Cost savings realized by the divisions.

We also found that division management never established objectives against which it can evaluate the results of using KOLEA to streamline the eligibility and enrollment processes. To understand the relationship between the division's activities and its results, management needs to develop objectives that results can be measured against. However, the division's only performance targets are the 45- and 90-day federal time standards for determining eligibility. This reflects management's narrow focus on application volume and processing times and its inattention to gauging the efficiency of its new eligibility and enrollment processes. The division's assistant administrator acknowledged that management is most concerned about the division's ability to process the volume of applications within federally-established time standards.

Agencies can achieve more efficient and effective processes that deliver desired outcomes by using performance information to identify what does and does not work. In contrast, division management relies on meetings with and feedback from staff to identify and address problems and issues with KOLEA, eligibility, and enrollments. While staff feedback is useful and important to consider, it is also subjective.

The division has formed a task force consisting of representatives from various branches to find solutions for operational problems with KOLEA that impact the entire division. There is also a KOLEA work group that focuses on operations issues specifically related to the Eligibility Branch. Both groups are involved in prioritizing KOLEA system fixes and enhancements.

CMS pilot program offers glimpse of the scope of eligibility error rates

CMS is conducting a 50-state pilot program to inform its efforts to establish new eligibility review rules and methodologies in light of changes to eligibility requirements under ACA. Hawai'i has produced two reports under this pilot project. As shown in Exhibit 2.4, the overall Medicaid and CHIP determination and renewal error rate was 1.8 percent in the first pilot review period and 4.4 percent in the second review period.

**Exhibit 2.4
Hawai'i Medicaid and CHIP Eligibility Determination Error Rates**

Pilot Period	Determination Cases	Determination Errors	Determination Error Rate	Renewal Cases	Renewal Errors	Renewal Error Rate	Total Cases	Total Errors	Total Error Rate
October 2013 to March 2014	220	4	1.8%	0	0	0	220	4	1.8%
April 2014 to September 2014	62	1	1.6%	167	9	5.4%	229	10	4.4%

Source: Office of the Auditor

The eligibility reviews under the pilot excluded certain types of cases such as MAGI-excepted cases. MAGI-excepted individuals include those who are age 65 or older, blind, disabled, medically needy, and those requesting long-term care coverage or Medicare cost-sharing assistance. Therefore, pilot program error rates do not represent Hawai'i's overall Medicaid program error rate. Moreover, error rates may vary from current levels when CMS finally produces a new methodology for testing eligibility accuracy. Nonetheless, the pilot error rates can be used to demonstrate the potential impact of improper eligibility determinations. The most recent error rate of 4.4 percent applied to Hawai'i's July 2014 Medicaid and CHIP enrollment of 325,510 equates to approximately 14,300 individuals whose eligibility may have been improperly determined. Consequently, the impact of improper eligibility determinations can be significant given the scope of Hawai'i's Medicaid program.

Enterprise System Does Not Yet Support Human Services Programs, but Integration Is in Progress

KOLEA is the first phase of the department's effort to develop an integrated, department-wide human services IT platform. Because of the compressed timeframe in which it had to comply with the ACA's new requirements, the department focused on developing a system to support the Med-QUEST Division's MAGI-based expanded Medicaid eligibility requirements. The result was KOLEA.

The next phase will entail developing a system to support the Benefit, Employment, and Support Services (BESSD) and Social Services (SSD) division's programs, which include SNAP and TANF. This will include enhancing KOLEA so it can be used by all three divisions' benefits programs.

The department has not received final approval of its plans from the federal government.¹ Meanwhile, the department is working on the RFPs to select vendors for BESSD and SSD to design and develop the integrated functionality, and to perform independent verification and validation (IV&V) services for the designs. RFPs are scheduled to be issued in December 2015. The department will need to oversee, manage, and coordinate these multiple development efforts during project initiation and planning, solution design, system development, training, and testing of the new integrated systems. Current projections indicate that the BESSD and SSD systems will take two and 3.5 years, respectively, to complete.

The integration of health insurance with human services programs is critical to helping Hawai'i's needy

Section 1561 of the ACA requires the federal Department of Health and Human Services (DHHS) to establish standards for how new information technology systems will support applications for health coverage that also connect families to other human services benefits. The law requires states to seamlessly connect individuals to Medicaid, CHIP, or the state's health insurance exchange, regardless of where they apply ("no wrong door").

Cross-program integration is critical because providing low-income individuals and families with access to all benefits for which they are eligible is key to helping them make ends meet and stabilizing their circumstances. Helping families overcome poverty and become self-sufficient requires a coordinated approach to delivering benefits. Without integration, major eligibility system changes can lead to families losing benefits.

ACA requires states to facilitate enrollment in health and human services programs

The ACA made significant changes to the eligibility determination process for health and human services programs to reduce consumers' burdens when they seek coverage, cut administrative costs, and prevent eligibility errors—changes that have required major improvements to information technology systems. The ACA requires states to be able

¹ CMS, DHHS' Administration for Children and Families; and the Department of Agriculture's (USDA) Food, Nutrition and Consumer Services

to expand their enrollment systems to integrate new programs, rules, and functionalities, and be able to apply streamlined verification and eligibility processes to other federal and state health and human services programs, as appropriate.

Recognizing the need for states to receive federal financial support in this endeavor, on April 14, 2011, the federal CMS announced that it would provide enhanced, 90 percent federal funding to states' 10 percent match for states to modernize their Medicaid IT eligibility determination systems through December 31, 2015. Previously, states were only eligible for 50 percent federal funding.

On August 10, 2011, the federal government² announced it would allow, for a limited time, states' federally funded human services programs to benefit from investments in state eligibility systems being made by state-operated healthcare exchanges, state Medicaid programs, and state CHIPs. The announcement allowed states' human services programs (including TANF and SNAP) to use IT systems designed for determining eligibility for health coverage programs (such as Medicaid, CHIP, and premium tax credits and cost sharing benefits through a healthcare exchange) without paying for common system development costs, as long as the costs would have been incurred anyway to develop systems for the exchanges, Medicaid, and CHIP. This announcement applied only to development costs for eligibility determination systems, and was scheduled to terminate on December 31, 2015.

Time constraints led DHS to prioritize Medicaid in building KOLEA and delay the integration of human services programs

The department decided not to pursue the enhanced 90/10 federal funding or the allowance to leverage with non-health benefit programs (such as SNAP and TANF) in the initial phase of its Medicaid IT upgrade project. According to the department's deputy director, the decision was primarily based on the fact that it did not believe the integration of SNAP and TANF programs with the KOLEA application could be accomplished before the October 1, 2013, "go-live" deadline, which was less than nine months away at the time. The deputy director explained that the differences between Medicaid and the SNAP and TANF programs would have made simultaneous integration in the compressed timeframe too difficult. For example, the IRS allowed direct access to its database for Medicaid only. In addition, definitions of "household" under SNAP and TANF differed from Medicaid, which now follows MAGI-based eligibility rules.

² CMS; DHHS' Administration for Children and Families; and the U.S. Department of Agriculture's (USDA) Food, Nutrition and Consumer Services

BESSD participated in the discussions to integrate its programs with KOLEA and agreed with the department's decision to focus KOLEA's development on supporting only Medicaid eligibility. The BESSD administrator was confident that the division would be able to integrate its programs with the KOLEA application in the second phase of the project.

According to the American Public Human Services Association (APHSA), failure to include human services program representatives when attempting to make their Medicaid eligibility systems interoperable with the rest of CMS' standards and conditions can result in increased costs, delays, and cost overruns. When developing new IT systems, it is always more cost-effective and efficient to design multi-program coordination capacity from the start, rather than retrofitting the IT system later. According to APHSA, historically, the development of integrated eligibility determination systems has taken four to five years from start to finish in the best of circumstances. Under the ACA's statutorily imposed deadlines, Medicaid agencies had fewer than 18 months to build and thoroughly test new eligibility and enrollment systems or enhance their existing systems.

Extension of the enhanced federal funding buys DHS more time

The department's decision to prioritize Medicaid eligibility in the first phase of its IT modernization project meant the integration of BESSD and SSD programs would have to have been completed by December 31, 2015, or Hawai'i would lose the enhanced federal funding opportunities. We found that prior to the ACA, 45 state Medicaid eligibility and enrollment programs were integrated with other public assistance programs such as SNAP or TANF. However, due to the large scale of the ACA changes, many states delinked these other programs when upgrading or building their new Medicaid eligibility systems. As of January 1, 2015, only 19 states have systems that support Medicaid eligibility and at least one other non-health benefit program (such as SNAP, cash assistance, or child care subsidies).

CMS recognized most states have not had sufficient time to complete a total IT system replacement, and that without ongoing enhanced federal funding, state Medicaid eligibility and enrollment systems are likely to become out of date. CMS further noted that states are in varying stages of completion of their eligibility and enrollment system functionality, and the majority are engaged in system integration with human services programs, further increasing efficiencies and improving the customer experience for those seeking benefits or services from programs in addition to Medicaid.

In October 2014, CMS therefore announced a three-year extension of the waiver enabling states to complete their work on integration of eligibility systems between health and human services programs, such as SNAP and TANF, through December 2018. In addition, in April 2015, CMS proposed codifying availability of the 90/10 federal matching funds for Medicaid eligibility and enrollment systems on a permanent basis. CMS initially considered a two- or three-year extension but decided that was too short for states to effectively transition from their legacy IT systems and complete integration of their human services programs into their new, shared eligibility systems.

Integration of SNAP and TANF programs are underway, but much work remains

According to CMS, states pursuing an integrated eligibility system strategy should consider mechanisms for phasing their IT development, so that additional functionality needed to determine eligibility for human services programs can be added after health components are operational. States therefore have the option to implement a shared eligibility system through a phased approach to better enable them to implement health components of an enterprise system in accordance with ACA requirements. Phased projects are allowable under CMS' extended funding waiver.

The department has already begun efforts to integrate BESSD and SSD programs' IT system with KOLEA through an enterprise platform of shared components and services. As of September 2015, the department's implementation plan and procurement strategy was not finalized. The department intends to issue RFPs to select vendors for the design, development, and implementation of the new systems as well as an IV&V vendor in December 2015. As a result, multiple development efforts will need to be coordinated during project initiation and planning, solution design, system development, training, and testing of the new integrated systems.

DHS must overcome data-sharing challenges among multiple divisions

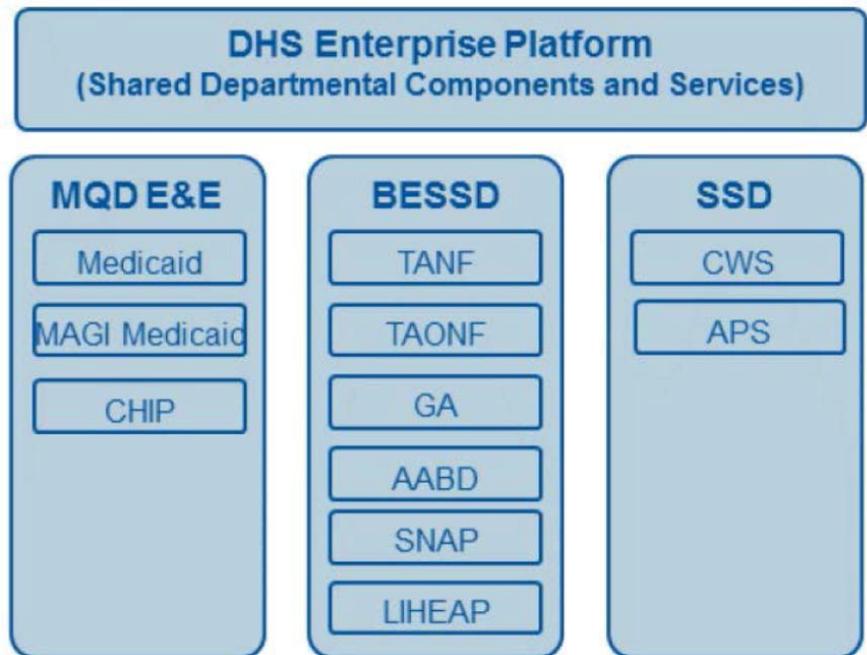
The department has embarked on the challenge of building integrated and interoperable eligibility determination systems, as well as an enterprise-wide application design capable of linking databases from various divisions that serve the same clients. In addition, the department must develop strategies to effectively leverage its investments in technological components and take advantage of federal funding opportunities without sacrificing quality product and results.

In late 2013, following the implementation of KOLEA, the department started planning how to expand KOLEA to support other DHS programs. This included analyzing BESSD and SSD programs and understanding

what was required to enhance KOLEA so it can be leveraged by multiple divisions and become the DHS Enterprise Platform.

The department’s vision is to move all its divisions’ programs onto the new platform. This will include developing the required BESSD functionality by leveraging KOLEA as much as possible and adding the capabilities for other applications to integrate with the platform. BESSD will retire its legacy HAWI system, which currently supports TANF; Temporary Assistance for Other Needy Families (TAONF); General Assistance (GA); Aid to the Aged, Blind, and Disabled (AABD); SNAP; and the Low Income Home Energy Assistance Program (LIHEAP). Future phases will include modernizing the current system that supports SSD’s Child Welfare Services (CWS) and Adult Protective Services (APS) programs. Exhibit 2.5 illustrates the new DHS Enterprise Platform.

Exhibit 2.5
Diagram of DHS Enterprise Platform



Source: Department of Human Services

DHS may not meet deadline for federal funding opportunities

BESSD and SSD each submitted plans for this integration to the federal government in November 2014. In December 2014, the Med-QUEST Division submitted to the federal government a draft update of its integration plan that described proposed enhancements to KOLEA’s Medicaid eligibility services. After reviewing the integration plans,

the federal government decided that a consolidated integration plan—one that includes BESSD and SSD’s plans and the department’s draft KOLEA update plan—would more accurately capture the department’s effort to leverage its and the federal government’s investments in establishing an integrated human services enterprise-wide IT platform.

Accordingly, the department has submitted four of eight sections of its revised, consolidated integration plan to the federal government. The department is now reconsidering its procurement strategy and analyzing alternatives to procuring the various services required—hosting; maintenance and operations; and design, development, and implementation—for the DHS Enterprise Platform, and the design, development, and implementation services for Med-QUEST, BESSD, and SSD.

The department plans to release RFPs in December 2015 to select vendors who will assist the department with expanding KOLEA to provide eligibility support for all DHS programs and services. Vendors will be required to use KOLEA’s existing software components wherever possible, as this infrastructure has already been secured and paid for by the KOLEA project. A design, development, and implementation vendor for the new BESSD system was initially scheduled to be selected in April 2015, with a project completion date of April 2017. The design, development, and implementation vendor for SSD was to be selected in September 2015, with project completion in March 2019. However, since the department has not yet obtained approval of its revised, comprehensive integration plan from the federal government, extended dates are expected. Consequently, the department may not be able to maximize its opportunities under the federal waiver, which now expires on December 31, 2018.

Conclusion

The Department of Human Services must continue to enhance the KOLEA system to comply with the provisions of the federal *Affordable Care Act* and support the Med-QUEST Division’s Medicaid eligibility policies and processes. The goal is to achieve an IT system that applies new ACA rules to determine eligibility for the Medicaid program, operates seamlessly with the federal health exchange, and electronically verifies income from applicants.

The department will face similar challenges as it integrates its human services programs into a new, department-wide enterprise IT platform that extends the KOLEA application. The department’s director must ensure that problems encountered in planning and developing KOLEA are not repeated, and that lessons learned appropriately guide future IT system transformations. Further investments in new technology should

be justified by improvements in the consumer experience for those seeking benefits or services from the programs, as well as increased efficiencies for the department.

Recommendations

1. The director of human services should:
 - a. **Lead future departmental IT changes** by ensuring rigorous project process standards are defined to guide the project, there is a clear structure for decisionmaking, individuals in lead roles have the right skills for the project, and those individuals appropriately execute their responsibilities; and
 - b. **Address Medicaid income verification issues** and increase the likelihood that Hawai'i's neediest people are receiving all the benefits for which they qualify by:
 - i. Finalizing the Memorandum of Agreement with the Department of Labor and Industrial Relations so that the Med-QUEST Division can perform data matching with state wage information and perform real-time income verifications; and
 - ii. Ensuring the Med-QUEST Division establishes an interface with the Internal Revenue Service to check unearned income or ensuring the Hawai'i Administrative Rules are revised to remove this requirement.
2. The Med-QUEST Division administrator should:
 - a. **Ensure that KOLEA project responsibilities are clearly defined** between functional areas and actively manage those responsibilities to avoid gaps in, and enforce, responsibilities as necessary;
 - b. **Facilitate efforts to improve the division's eligibility and enrollment processes** and address KOLEA's functionality and usability issues by:
 - i. Establishing goals, objectives, performance targets, and performance measures for the Medicaid eligibility and enrollment processes that align with the department's overall mission, goals, and objectives and are useful for decisionmaking. The administrator should include

- managers at different organizational levels in the development of these performance goals;
 - ii. Ensuring KOLEA is modified so that it can generate reports on relevant performance measures; and
 - iii. Periodically reviewing and discussing with relevant stakeholders the progress made toward improving the division's eligibility and enrollment processes and KOLEA's functionality and usability issues;
- c. **Ensure the division's Policy and Program Development Office:**
- i. Evaluates and updates the department's administrative rules, policies, and procedures regarding Medicaid enrollment and eligibility pursuant to requirements in the *Affordable Care Act*. The office should ensure administrative rules adhere to all applicable provisions of the ACA including income verification requirements, conform with the Notice of Proposed Rulemaking, align with the department's Verification Plan, and include business processes that optimize KOLEA's efficiency;
 - ii. Works with the Eligibility Branch to:
 - 1. Along with other stakeholders and experts, examine the state's Medicaid application and eligibility determination process and establish a new one that complies with the department's administrative rules;
 - 2. Reassess Eligibility Branch staff's responsibilities in light of the new statutory framework pursuant to the ACA and KOLEA-automated processes; and
 - 3. Develop an appropriate training program for Eligibility Branch workers. The program should include changes to the ACA, the division's new policies and procedures, and how to navigate KOLEA;
- d. **Address KOLEA functionality and usability issues by:**
- i. Seeking input from the policy office, Eligibility Branch, and other stakeholders and experts to identify weaknesses in the division's eligibility and enrollment processes and KOLEA and their causes; and develop a strategy for, and allocate

resources to, support improvement; and

- ii. Continuing to work with KPMG, LLP to address functionality and usability issues so eligibility workers can use KOLEA more efficiently and effectively; and
- e. **Ensure the division's Training Office** works with the policy office and KOLEA Project Team as necessary to develop and provide appropriate training to Eligibility Branch staff on new eligibility and enrollment processes and requirements, and navigating KOLEA. Training should be provided periodically as rules, policies, procedures, and KOLEA are modified.

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Human Services on December 14, 2015. A copy of the transmittal letter is included as Attachment 1 and the department's response, dated December 22, 2015, is included as Attachment 2.

The department, which requested this audit, said it appreciated most of our recommendations but disagreed with our two primary findings. Although it claims our main findings are "incorrect" and provided lengthy clarifications that it described as "objective information," we note that the department agreed with all but one of our recommendations and provided comments on how it is addressing, or plans to address, them. Pursuant to the professional standards under which we conduct our audit work, recommendations flow logically from findings and conclusions and are directed at resolving the cause of identified deficiencies and findings.¹ We stand by our recommendations and their underlying findings.

The department disagreed with our recommendation to establish an interface with the IRS for unearned income, noting there is no ACA mandate to do so. We do not dispute this; however, the department should amend its own administrative rules to delete this provision if it does not intend to establish the interface with the IRS.

Regarding our first finding, the department contends that KOLEA has achieved the ACA's goals and meets all of the requirements for a Medicaid eligibility determination system because, it says, KOLEA accepts online applications, is connected to the federal data hub to conduct online verifications, and determines eligibility in a timely and accurate manner as confirmed by CMS. As we state in the report, a primary goal of the ACA is 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 a determination. Although KOLEA can electronically verify citizenship, social security number, and Social Security income benefits, it does not access quarterly wage data from Hawai'i's Department of Labor and Industrial Relations, self-employment income, or unearned income. In addition, we found that administrative efficiencies and reduced paperwork have not been realized as evidenced by statements from eligibility workers, supervisors, and branch management, all of whom have hands-on experience working with KOLEA. We therefore stand by our finding.

¹ *Government Auditing Standards* (2011 Revision), paragraph 7.28

With respect to our second finding, the department claims there is no ACA requirement that other human services programs (such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families) be included in the streamlined eligibility system. The department misses our point. While it is true the ACA does not require they be included, it does require—as stated in our report—that states must facilitate enrollment in health and human services programs. *Human services programs* includes SNAP, TANF, the Low Income Home Energy Assistance Program, Supplemental Security Income, Child Care and Development Fund, and similar programs. We stand by our finding.

The department also made comments on our audit process and data collection. We note that we requested, but never received, all DHS reports made to CMS, which likely would have contained feedback from CMS. Also contrary to the department's allegations, we did interview eligibility workers from community health centers.

We incorporated some of the department's clarifications in the final report but left out those that do not alter the factual findings. We also made minor technical corrections for accuracy, clarity, and style prior to publication.



December 14, 2015

COPY

The Honorable Rachael Wong
Director
Department of Human Services
Queen Lili'uokalani Building
1390 Miller Street
Honolulu, Hawai'i 96813

VIA EMAIL ONLY: rswong@dhs.hawaii.gov

Dear Dr. Wong:

Attached for your information is a .pdf of our confidential draft report no. 4, *Audit of the Department of Human Services' KOLEA System*. We ask that you telephone us by Wednesday, December 16, 2015, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit your hard copy response to our office no later than 12:00 p.m., Monday, December 21, 2015.

The Governor and presiding officers of the two houses of the Legislature have also been provided .pdf copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Jan K. Yamane
Acting State Auditor

Attachment

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

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OFF. OF THE AUDITOR
STATE OF HAWAII

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 Eligibility 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 Verification 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 eligibility 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

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.ihl.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).

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). This 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:

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 initial 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: Proposed 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.