17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Christopher J. Giese, FSA, MAAA
Principal and Consulting Actuary

chris.giese@milliman.com

Attachment B
Bid Submission Letter

[NOTE: Bidders should use their business letterhead. Failure to submit a letter in this format with the required information may result in disqualification of your bid as non-responsive]

Date: September 29, 2023
Bidder Name: Milliman, Inc.
Address of Bidder's Principal Place of Business: 17335 Golf Parkway, Suite 100, Brookfield, WI 53046
Bidder's Telephone Number: 262 784 2250
Bidder's Fax Number: 262 923 3680
Bidder's Email Address: chris.giese@milliman.com
Name of Contract Person, if different from Bidder Name: Chris Giese

Re: Response Submission for DSHS Competitive Solicitation #2334-830

Dear Sir or Madam:

1. Enclosed please find the Response of Milliman, Inc. (Bidder) with respect to the above Competitive Solicitation. This Response includes this Letter (Attachment B) as well as Attachments C (Bidder Certifications), D (Bidder Response Form), E (Contractor Inclusion Plan), and F (Budget Template), as set forth in the Solicitation Document. In addition to these completed Attachments, the response includes the following additional materials:

    - RFP2334-830_Supplement D.1.d - Exceptions to Attachment A-Sample Contract.docx

    - RFP2334-830_Supplement D.5.e - SD1_Rate Study.pdf

2. I am authorized to submit this Response on behalf of Bidder, to make representations on behalf of Bidder and to commit Bidder contractually.

Milliman

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3. I have read the Solicitation Document and Sample Contract. In submitting this Response, Bidder accepts all terms and conditions stated in the Solicitation Document, including those set forth in the following amendments which Bidder has downloaded (please complete, indicating if no amendments were issued):

Amendment Number / Description	Date Issued
Amendment 1	September 1, 2023
Amendment 2	September 7, 2023
Amendment 3	September 21, 2023
Amended Solicitation Document	September 21, 2023
Amended Attachment D	September 21, 2023
Attachment F	September 21, 2023

4. Bidder represents that it meets all minimum qualifications set forth in this DSHS Competitive Solicitation and is capable, willing and able to perform the services described in the DSHS Competitive Solicitation within the time frames set forth for performance.

5. By my signature below, I certify that all statements and information provided in Bidder's Response are true and complete.

Sincerely,

Christopher J. Giese

Christopher J. Giese, FSA, MAAA
Principal and Consulting Actuary

Attachment C
Bidder Certifications and Assurances

Bidder must sign and include the full text of this Attachment C with the Response. Altering or conditioning your certification of this Attachment C may result in your bid being disqualified.

Under the penalties of perjury of the State of Washington, Bidder makes the following certifications and assurances as a required element of its Response to this Competitive Solicitation. Bidder affirms the truthfulness of these facts and acknowledges its current and continued compliance with these certifications and assurances as part of its Response and any resulting contract that may be awarded by DSHS.

1. Bidder declares that all answers and statements made in Bidder's Response are true and correct.

2. Bidder certifies that its Response is a firm offer for a period of 180 days following receipt by DSHS, and it may be accepted by DSHS without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-day period. In the case of a protest, the Bidder's Response will remain valid for 210 days or until the protest is resolved, whichever is later.

3. Bidder has not been assisted by any current or former DSHS employee whose duties relate (or did relate) to this Solicitation and who assisted in other than his or her official, public capacity. If there are any exceptions to these assurances or if Bidder has been assisted, Bidder will identify on a separate page attached to this document each individual by: (a) name, (b) current address and telephone number, (c) current or former position with DSHS, (d) dates of employment with DSHS, and (e) detailed description of the assistance provided by that individual.

4. Bidder certifies that Bidder is not currently bankrupt or a party to bankruptcy proceedings and has not made an assignment for benefit of creditors and authorizes DSHS to conduct a financial assessment of Bidder in DSHS' sole discretion.

5. Bidder acknowledges that DSHS will not reimburse Bidder for any costs incurred in the preparation of Bidder's Response. All Responses shall be the property of DSHS. Bidder claims no proprietary right to the ideas, writings, items or samples submitted as part of its Response.

6. Bidder acknowledges that any contract award will incorporate terms set forth in the Sample Contract(s), including its attachments and exhibits, as set forth as Attachment A to the Solicitation Document, or may, at DSHS' option be negotiated further. DSHS may elect to incorporate all or any part of Bidder's Response into the Contract.

7. Bidder certifies that it has made no attempt, nor will make any attempt, to induce any other person or firm to submit, or not submit, a Response for the purpose of restricting competition and that the prices and/or cost data contained in Bidder's Response: (a) have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition or influencing bid selection, and (b) have not been and will not be knowingly disclosed by the Bidder, directly or indirectly, to any other Bidder or competitor before contract award, except to the extent that Bidder has joined with other individuals or organizations for the purpose of preparing and submitting a joint Response or unless otherwise required by law.

8. Bidder acknowledges that if it is awarded a contract containing Business Associate requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or any other Data Security requirements, that Bidder will incorporate the terms of such Business Associate or Data Security requirements into all related subcontracts.

9. Bidder acknowledges that if awarded a contract with DSHS, Bidder is required to comply with all applicable state and federal civil rights and other laws. Failure to comply may result in contract termination. Bidder agrees to submit additional information about its nondiscrimination policies, at any time, if requested by DSHS.

10. Bidder certifies that Bidder has not, within the three-year period immediately preceding the date of release of this competitive solicitation, been determined by a final and binding citation and notice of assessment issued by the Department of Labor and Industries or through a civil judgment to have willfully violated state minimum wage laws (RCW 49.38.082; Chapters 49.46 RCW, 49.48 RCW, or 49.52 RCW).

11. Bidder certifies that it has a current Business License and agrees that it will promptly secure and provide a copy of its Washington State Business License, unless Bidder is exempted from being required to have one, if Bidder is awarded a contract.

12. Bidder authorizes DSHS to conduct a background check of Bidder or Bidder's employees if DSHS considers such action necessary or advisable.

13. Bidder has not been convicted nor entered a plea of *nolo contendre* with respect to a criminal offense, nor has Bidder been debarred or otherwise restricted from participating in any public contracts.

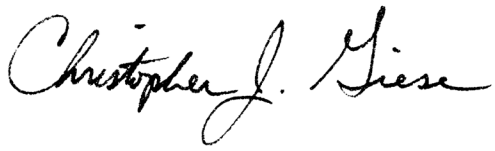
14. Bidder certifies that Bidder has not willfully violated Washington state's wage payment laws within the last three years.

15. Bidder certifies that Bidder is not presently an agency of the Russian government, an entity which is Russian-state owned to any extent, or an entity sanctioned by the United States government in response to Russia's invasion of Ukraine.

16. Bidder acknowledges its obligation to notify DSHS of any changes in the certifications and assurances above.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

Bidder's Signature:



Printed Name: Christopher J. Giese
Title: Principal and Consulting Actuary
Organization Name: Milliman, Inc.
Date: September 29, 2023
Place Signed (City, State): Brookfield, WI

ATTACHMENT D: BIDDER RESPONSE FORM This form is broken into Seven sections: Section 1. Administrative Response; Section 2. EO 18-03 Response; Section 3. Washington Small Business; Section 4. Certified Washington Veteran-owned Business; Section 5. Management Response; Section 6. Technical Response; and Section 7. Quotation/Cost Proposal. Bidders must respond to all questions in the order and in the expandable space provided. If a question requires Bidder to submit additional documents, please attach them to this document and label them clearly as part of your response to this Attachment D.		
1	**BIDDER INFORMATION (ADMINISTRATIVE RESPONSE)** Bidder's response to the questions in this Section 1, combined with the information provided in Bidder's Submittal Letter and Certifications and Assurances, comprise Bidder's Administrative Response to this Solicitation. While the Administrative Response is not given a number score, the information provided as part of Bidder's Administrative Response may cause the Bid to be disqualified and may be considered in evaluating Bidder's qualifications and experience.	**MAXIMUM TOTAL POINTS**
a	Please indicate whether you employ or contract with current or former state employees. If the answer is yes, provide the following information with respect to each individual: 1. name of employee or contractor; 2. the individual's employment history with the State of Washington; 3. a description of the Individual's involvement with the response to this Solicitation; and 4. the Individual's proposed role in providing the services under this any Contract that may be awarded.	NOT SCORED
	ANSWER: Milliman does not employ or contract with any current state employees. Within the Milliman offices that will be performing services under this RFP, we employ the following two former state employees: 1. Joseph Whitley a. Joseph was employed by the Health Care Authority as a Fiscal Information and Data Analyst from April 2016 to July 2018 b. Joseph did not contribute to the response to this Solicitation c. Joseph will have no role in providing services under the Contract that may be awarded 2. Benjamin Davis-Bloom a. Benjamin was employed by the Health Care Authority as a Program Management Analyst from 2016 to 2018, a Data Analyst from 2018 to 2021, and Program Manager from 2021 to May 2023 b. Benjamin did not contribute to the response to this Solicitation	

	c. Benjamin will have no role in providing services under the Contract that may be awarded	
b	Please list the names and contact information of three individuals you agree may serve as Bidder references and may freely provide information to DSHS regarding the reference's experience and impressions of Bidder. In providing these names, Bidder represents that it shall hold both DSHS and the organizations and individuals providing a reference harmless from and against any and all liability for seeking and providing such reference.	NOT SCORED
	ANSWER: 1. Luke Masselink, Senior Actuary Washington State Office of the State Actuary (360) 786-6140 Luke.Masselink@leg.wa.gov 2. Molly McCloskey, Health and Human Services Rate Review Director Office of the Health Insurance Commissioner, State of Rhode Island (401) 462-2144 molly.mccloskey@ohic.ri.gov 3. Jennifer Wentworth, Deputy Administrator for Finance Mississippi Division of Medicaid (601) 359-3147 Jennifer.Wentworth@medicaid.ms.gov	
c	Please indicate whether your Response contains any variations from the requirements of the Solicitation Document. If the answer is yes, list each variation with specificity and include the pertinent page numbers containing the variation.	NOT SCORED
	ANSWER: Our response does not include any variations from the requirements of the Solicitation Document.	

d	Please indicate whether you are requesting that DSHS consider any exceptions and/or revisions to the sample contract language found in Attachment A. If so, state the page of Attachment A on which the text you request to change is found, and state the specific changes you are requesting. DSHS shall be under no obligation to agree to any requested changes, and will not consider changes to contract language or negotiate any new language not identified in response to this question.	NOT SCORED
	ANSWER: Please see "RFP2334-830_Supplement D.1.d - Exceptions to Attachment A-Sample Contract.docx" for our requested exceptions and revisions to the sample contract language found in Attachment A.	
e	If Bidder considers any information that is submitted as part of its Response to be proprietary, please identify the numbered pages of Bidder's Response containing such information and place the word "Proprietary" in the lower right hand corner of each of these identified pages.	NOT SCORED
	ANSWER: No items are marked as proprietary.	
f	Please indicate whether you have had a contract terminated for cause or default within the past five (5) years. If so, please provide the terminating party's name, address and telephone number and provide a summary describing the alleged deficiencies in Bidder's performance, whether and how these alleged deficiencies were remedied and any other information pertinent to Bidder's position on the matter. "Termination for Cause" refers to any notice to Bidder to stop performance due to Bidder's asserted nonperformance or poor performance and the issue was either (a) not litigated; (b) litigated with a resulting determination in favor of the other party; or (c) is the subject of pending litigation.	NOT SCORED
	ANSWER: The Milliman offices and key personnel who will be performing services under this RFP have not had a contract terminated for cause or default within the past five years.	
g	Please identify any prior contracts Bidder has entered into with the State of Washington within the past ten (10) years and identify the dates and nature of the contract and primary agency contact for each.	NOT SCORED

ANSWER:

We list below the direct contracts Milliman has entered with the State of Washington for the past 10 years – the agencies include: Washington State Health Care Authority (HCA), Washington Department of Social and Health Services (DSHS), Washington State Office of the State Actuary (OSA), and the Washington Office of the Insurance Commissioner (OIC).

Washington State Agency	Contract Number	Dates	Agency Contact	Project Description
Washington State DSHS Aging & Long Term Support Administration	1532-49922	October 2015 – October 2018	Agency Contact: Kelli Emans, Integration Manager, Home and Community Services Division Aging and Long-Term Support Administration; E: kelli.emans@dshs.wa.gov P: 360-764-3017	Development of Medicaid capitation rates for Program of All-inclusive Care for the Elderly (PACE) agencies.
Washington State Department of Social and Health Services	1634-58494	February 2016 – January 2017	Agency Contact: Ben Veghte, Director WA Cares Fund, Aging and Long-Term Support Administration; E: benjain.veghte@dshs.wa.gov P: 571-345-4986	Feasibility Study of Policy Options to Finance Long-Term Services and Supports in the State of Washington
Washington State DSHS Aging & Long Term Support Administration	1822-33172	July 2018 – June 2023	Agency Contact: Kelli Emans, Integration Manager, Home and Community Services Division Aging and Long-Term Support Administration; E: kelli.emans@dshs.wa.gov P: 360-764-3017	Development of Medicaid capitation rates for Program of All-inclusive Care for the Elderly (PACE) agencies.

	Washington State DSHS Aging & Long Term Support Administration	1832-33029	July 2018 – June 2019	Agency Contact: Ben Veghte, Director WA Cares Fund, Aging and Long-Term Support Administration; E: benjamin.veghte@dshs.wa.gov P: 571-345-4986	Feasibility Study of Policy Options to Finance Long-Term Services and Supports in the State of Washington
	Washington State Department of Commerce and Andy Hill Cancer Research Endow-ment (CARE)	21-87101-100	January 2021 – June 2021	Agency Contract: Chris Green (Dept of Commerce), Fred Appelbaum (Andy Hill Research Endowment (CARE))	CARE Fund Program Review
	Washington Department of Commerce	21-87101-100	February 2021 - June 2021	Laura Cantrell	Andy Hill CARE Fund performance audit against regulations.
	Washington State Department of Social and Health Services	2234-42497	June 1, 2022 – March 31, 2024	Agency Contact: Valerie Kindschy, Community Residential Services Program Manager; E: Valerie.Kindschy@dshs.wa.gov; P: 360-407-1550	Rate Study for Contracted Community Residential Services

	Washington State DSHS Aging & Long Term Support Administration	2331-49183	July 2023 – December 2023	Agency Contact: Kelli Emans, Integration Manager, Home and Community Services Division Aging and Long-Term Support Administration; E: kelli.emans@dshs.wa.gov P: 360-764-3017	Development of Medicaid capitation rates for Program of All-inclusive Care for the Elderly (PACE) agencies.	
	State of Washington Office of the State Actuary	OSA_2019-21 OSA_2021-23	February 2020 – Current	Luke Masselink, Senior Actuary, E: luke.masselink@leg.wa.gov; P: 360-786-6154	Actuarial and consulting services to support Washington State's WA Cares Fund	
	State of Washington Office of the State Actuary	ID# 20292		Lisa Won, Deputy State Actuary, won.lisa@leg.wa.gov, (360)786-6147	Consulting services and OBEP assumptions	
	Washington State Health Care Authority	HBE-018	September 2012 - May 2014	Thuy Hua-Ly, Deputy CFO; P: 360-725-1855	Actuarial consulting services for the Washington Health Care Authority (HCA) including: Apple Health (Medicaid Managed Care); Washington Medicaid	

	Washington State Health Care Authority	HBE-038	January 2013 - December 2013		Integration Partnership; Dual Integration Demonstration; Policy Support	
	Washington State Health Care Authority	HBE-24	November 2012 - August 2013			
	Washington State Department of Health	Data Order Form: 0597133025	Annually (2005 through 2017)	Washington State Department of Health, Center for Health Statistics; E: CHS.DataRequests@doh.wa.gov; P: 360.236.4310	Milliman, Inc. will use the data in continuing actuarial analyses performed on behalf of clients of Milliman, Inc and in updates to actuarial tables and clinical guidelines published by Milliman. The data will be used to provide estimates of the utilization and cost of various inpatient procedures. In addition, the data will be aggregated by key parameters such as geographic area, payor and DRG, allowing for study of utilization, cost & length of	

				stay as compared with other reporting data sources.	
	Washington Office of the Insurance Commissioner	K202310	April 2022 - August 2023	Jane Beyer	Develop educational and information materials for OIC staff, providers, and interested parties. Complete project quarterly and yearly CMS grant reports.
	State of Washington Office of the Insurance Commissioner	K202312	May 2022 - November 2022	Bryon Welch, Deputy Commissioner Policy and Legislative Affairs; E: bryon.welch@oic.wa.gov	Provide an assessment of options related to access to and consumer protections regarding Medicare supplement insurance
	Washington State Health Care Authority - Financial Services Division	K2305	June 2017 – January 2018	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Payment Model 4 Data Extracts

	Washington State Health Care Authority Financial Services Division	K2428	August 2017 – December 2020	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Continuation of Medicaid, PEBB and SEBB actuarial services contract to assist with Medicaid capitation rate development, including ACA population rates and HSNA pass-through payments; PEBB and SEBB to assist with budget projections, self-insured plan management, and contributing to the Accountable Care Program. Also continuation of the Rural All-Payer Alternative Payment Model #2 contract.	
	Washington State Health Care Authority Financial Services Division	K2428 Work Order 14	March 2020 – June 2020	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Ad-hoc support, modeling, research, and support of state COVID-19 response for PEBB, SEBB, and Medicaid/non-Medicaid services.	
	Washington State Health Care Authority Financial Services Division	K2428 Work Order 15	May 2020 – June 2020	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Home Health FFS Encounter Rate Support	

	Washington State Health Care Authority Financial Services Division	K2428 Work Order 17	May 2021 – June 2022	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Medicaid Fee-for-Service (FFS) Hospital Inpatient and Outpatient Rebasing	
	Washington State Health Care Authority Financial Services Division	K2428 Work Order 8	March 2020 – June 2020	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	CY2021 Medicaid Capitation Rate Development Activities thru June 2020	
	Washington State Health Care Authority Financial Services Division	K2428 Work Order 9	February 2020 – December 2020	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Actuarial Support for PEBB	
	Washington State Health Care Authority - Financial Services Division	K2515	October 2017 – January 2018	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Development of the Rural All-Payer Alternative Payment Model #2.	

	Washington State Health Care Authority Financial Services Division	K2798	August 2018 – May 2019	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Conducted delivery system stakeholder structured interviews and provided summary findings to the HCA. Additionally, revised the Data Guide (dictionary) to reflect the HCA agency ownership vs. prior DSHS branding and newly identified element definitions.
	Washington State Health Care Authority	K2798	August 2018 - June 2019	Cathie Ott	Develop and implement corrective action plan in response to SAMHSA findings.
	Washington State Health Care Authority Financial Services Division	K3886	September 2019 – June 2021	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Development of annual hospital Safety Net Assessment Fund (SNAF) models, including calculations of hospital assessments, payment distributions, and managed care pass-through payment limits, as well as bi-weekly stakeholder meetings with WSHA.

	Washington State Health Care Authority Financial Services Division	K3886 Work Orders 1 - 3	September 2019 – June 2024	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Hospital Safety Net Assessment Fund Program Modeling and Support	
	Washington State Health Care Authority Financial Services Division	K4889	June 2021 – Current	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Actuarial consultant services for the following HCA programs, projects, and divisions: 1. Public Employees Benefits Board (PEBB) 2. School Employees Benefits Board (SEBB) 3. Apple Health Programs 4. Community Behavioral Health 5. Affordable Care Act 6. Division of Health Care Policy 7. Health Technology Assessment Program 8. Office of the Medical Director 0 9. Prescription Drug Program 10. Washington Wellness 11. Payment and Delivery System Reform efforts 12. Program of all-inclusive care for the elderly (PACE)	

	Washington State Health Care Authority Financial Services Division	K4889 Work Order 1	January 2022 – June 2022	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Upper Payment Limit Support	
	Washington State Health Care Authority Financial Services Division	K4889 Work Order 3	January 2022 – June 2023	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	SEBB Actuarial Support	
	Washington State Health Care Authority Financial Services Division	K4889 Work Order 4	January 2022 – June 2023	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	PEBB Actuarial Support	
	Washington State Health Care Authority Financial Services Division	K4889 Work Order 5	December 2021 – March 2022	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Tax Model Support	

	Washington State Health Care Authority Financial Services Division	K5962 Work Order 1	June 2023 – June 2026	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Psychiatric Hospital Rate Setting, Upper Payment Limit Demonstrations, and Acute Hospital Rate Support	
	Washington State Health Care Authority Financial Services Division	K731	April 2013 – June 2017	Agency Contact: Megan Atkinson, Chief Financial Officer, Financial Services Division; E: megan.atkinson@hca.wa.gov P: 360-764-3424	Medicaid/PEB actuarial services	
h	Please indicate whether Bidder has been the subject of a lawsuit or administrative proceeding alleging a failure to comply with laws relating to the types of services Bidder proposes to provide pursuant to this Competitive Solicitation. If the answer is yes, please list the nature of the allegations, docket number, disposition and date (if applicable) and Bidder's explanation of how it has changed its practices or operations relative to any alleged deficiencies since that proceeding was filed.					NOT SCORED
	ANSWER: With over 80 offices throughout the world, Milliman is subject to litigation from time to time in the normal course of its business activities. Such suits can arise in a variety of contexts. No litigation currently pending against Milliman will interfere with or jeopardize Milliman's ability to provide any of the services included in this proposal.					
i	Please describe your proposed plans for the use of Subcontractors in performing this contract, listing each Subcontractor, its proposed role and the estimated percentage of the Contract that will be performed by each Subcontractor. Please indicate whether each subcontractor self-identifies or is certified as a small business, a minority-owned business, a woman-owned business, a disadvantaged business enterprise, or a veteran-owned business. If the answer is yes, please identify the type of organization(s) and provide details of any certifications. Note that all Subcontractors must be approved by DSHS.					NOT SCORED
	ANSWER:					

	No Subcontractors will be used to perform the services for this contract.	
J	Please describe any programs, policies or activities of your organization that support human health and environmental sustainability in your business practices. If a program, policy or activity is specifically applicable to this Contract, please indicate so.	NOT SCORED
	ANSWER: Milliman is committed to the communities in which we live and work. While we do not believe any of these policies or activities are specifically applicable to this Contract, we provide below examples of volunteering and other initiatives that are typical of the Milliman culture. **Environmental** Milliman's mission is to help our clients protect the health and financial well-being of people everywhere. There is no risk and no need for protection more dire than that of climate change on our planet. This effort first starts at home, living our mission through a strong belief that our firm's global environmental impact must be understood, monitored, comprehensively accounted for, and ultimately mitigated. Milliman has taken important steps to demonstrate our commitment to the environment: • Milliman's Sustainability and DEI Officer manages our sustainability impacts and performance. • Milliman publicly reports its carbon footprint data to the CDP (Carbon Disclosure Project). Our CDP score is available upon request by emailing socialimpact@milliman.com. • In 2021, we established a baseline for greenhouse gas (GHG) emissions and have begun the process of creating a comprehensive sustainability strategy that will include science-based carbon emission reduction targets with the goal of Net Zero. • In 2022, Milliman's Board of Directors approved our firmwide, long-term carbon mitigation strategy: Net Zero 2040. While we are in the early stages of our Net Zero journey – including target verification through SBTi – we are focused on reducing our GHG footprint by 1% annually.	

- In terms of water and waste reduction, Milliman offices continuously engage in local efforts to mitigate waste, often in the form of single-use plastic reduction or elimination, shifting to reusable materials and providing said materials to staff, switching to more environmentally friendly single-use materials such as compostable plates, cups, and cutlery, and reducing paper use/waste by converting to digital formats when possible. These are often driven by local office Green Teams, which are set up to drive such efforts in our highly distributed structure, comprised of over 80 offices across the globe.

While knowing and mitigating our own environmental impact is critical, we also carry this same critical focus in the work we do with our clients and with other businesses, NGOs, and governments worldwide. We live our mission through projects and work that truly make a difference for those at the greatest risk from the effects of climate change. Examples include:

- MicroInsurance Centre at Milliman – we design crop insurance that protects Ethiopian farmers from loss of income related to climate change, and our insurance experts work to create better coverage for flood insurance. Using our deep expertise to perform risk analysis of shifting flood hazards because of climate change through advanced modeling and data innovation, we are able to provide more options and better coverage for those at risk.
- Milliman is leading the charge in providing thought leadership and education on the topic of climate resiliency. In 2021, we held the Climate Resiliency Forum, an educational and collaborative conference attended by industry leaders across multiple sectors interested in addressing climate change.
- Milliman Climate Resilience Initiative (MCRI) – a coalition to unite perspectives across industry, government, academic, and not-for-profit sectors to anticipate and measure the most pressing climate risks and drive effective responses.

Social impact and philanthropy

As a signatory of the United Nations Global Compact since 2019, Milliman submits an annual report called the UN Global Compact Communication on Progress. We also publish an annual social impact report that is posted to milliman.com/social-impact. Milliman also reports annually to EcoVadis, Integrity Next, and the CDP (Carbon Disclosure Project). All reports are available upon request by emailing socialimpact@milliman.com.

	The Milliman Giving Fund, our employee/retiree-funded philanthropy, has provided over $4M in grants to the following organizations since 2019: • Actuarial Foundation's Math Motivators tutoring program • Direct Relief - Ukraine relief • International Committee of the Red Cross - Ukraine relief • Opportunity International - Mityana, Uganda Opportunity Zone, and COVID-19 relief • Partners in Health - Healthcare access on Navajo Nation, and COVID-19 relief • PATH - COVID-19 relief • Splash Project Wise - Water, sanitation, and hygiene • VillageReach - COVID-19 relief	
2	**BIDDER EO 18-03 CERTIFICATION**	MAXIMUM TOTAL POINTS
EO	Are your employees required to sign, as a condition of employment, a mandatory individual arbitration clause and/or a class or collective action waiver? **Please Note:** Points for this question will be awarded to bidders who respond that they do not require these clauses and waivers. If you certify here that your employees are NOT required to sign these clauses and waivers as a condition of employment, and you are the successful bidder, a term will be added to your contract certifying this response and requiring notification to DSHS if you later require your employees to agree to these clauses or waivers during the term of the contract.	5
	ANSWER: Milliman employees are NOT required to sign, as a condition of employment, a mandatory individual arbitration clause or a class or collective action waiver.	
3	**BIDDER CERTIFICATION –WASHINGTON SMALL BUSINESS**	MAXIMUM TOTAL POINTS
EO	Are you a Washington Small Business as defined under **RCW 39.26.010**?	5

	According to **Chapter 39.26.010 RCW**, to qualify as a Washington Small Business, Bidder must meet three (3) requirements: a. *Location*. Bidder's principal office/place of business must be located in and identified as being in the State of Washington. A principal office or principal place of business is a firm's headquarters where business decisions are made and the location for the firm's books and records as well as the firm's senior management personnel. b. *Size*. Bidder must be owned and operated independently from all other businesses and have either: (a) fifty (50) or fewer employees; or (b) gross revenue of less than seven million dollars ($7,000,000) annually as reported on Bidder's federal income tax return or its return filed with the Washington State Department of Revenue over the previous three consecutive years. c. *WEBS Certification*. Bidder must have certified its Washington Small Business status in Washington's Electronic Business Solution (WEBS).	
	ANSWER: No, Milliman does not qualify as a Washington Small Business as defined under RCW 39.26.010.	
4	**BIDDER CERTIFICATION – CERTIFIED WASHINGTON VETERAN-OWNED BUSINESS**	MAXIMUM TOTAL POINTS
EO	Are you a Certified Washington Veteran-Owned Business as defined under **RCW 43.60A.190**? According to **Chapter 43.60A.190 RCW**, to qualify as a Certified Washington Veteran-Owned Business, Bidder must meet Four (4) requirements: *a. 51% Ownership. Bidder must be at least fifty-one percent (51%) owned and controlled by:* *1. A veteran is defined as every person who at the time he or she seeks certification has received a discharge with an honorable characterization or received a discharge for medical reasons with an honorable record, where applicable, and who has served in at least one of the capacities listed in*	5

	RCW 41.04.007; *2. A person who is in receipt of disability compensation or pension from the Department of Veteran's Affairs; or* *3. An active or reserve member in any branch of the armed forces of the United States, including the national guard, coast guard, and armed forces reserves.* *b. Washington Incorporation/Location. Bidder must be either an entity that is incorporated in the state of Washington as a Washington domestic corporation or, if not incorporated, an entity whose principal place of business is located within the State of Washington.* *c. WEBS Certification. Bidder must have certified its Veteran-Owned business status in Washington's Electronic Business Solution (WEBS).* *d. WDVA Certification. Bidder must have provided certification documentation to the Washington Department of Veterans' Affairs WDVA) and be certified by WDVA and listed as such on WDVA's website (WDVA – Veteran-Owned Businesses).*	
	ANSWER: No, Milliman does not qualify as a Certified Washington Veteran-Owned Business as defined under RCW 43.60A.190.	

5	BIDDER QUALIFICATIONS AND EXPERIENCE (MANAGEMENT RESPONSE)	MAXIMUM TOTAL POINTS: 240
	DESIRED EXPERIENCE AND QUALIFICATIONS	
A	Please provide the number of years of experience your organization has conducting rates studies and how many years specific to conducting rates studies regarding Long-Term Care services. Please describe the experiences, skills, and qualifications your organization possesses that are relevant to an evaluation of your ability to perform the Contract that is the subject of this Solicitation. Please ensure that your answer to this question includes all information that you wish DSHS to consider in determining whether you meet the minimum Bidder qualifications set forth in the Solicitation Document. Please include any relevant experience that distinguishes your organization or makes it uniquely qualified for the Contract.	50
	ANSWER: Milliman has 30+ years of experience in advising clients on a variety of areas related to analysis of LTSS services and rate studies. Our organization's experience includes assisting LTSS / LTC programs in both the public and private sectors, experience that will be directly relevant for completing the rate study for this engagement. We have 30+ years of experience conducting rates studies and fee schedule analysis more broadly for commercial and government healthcare programs. We have 15+ years of direct experience assisting Medicaid programs in conducting rates studies regarding LTSS / LTC services. We highlight below relevant work experience and examples, including work to project service costs to support the actuarial analysis of premium rates, fund balance, and viability of program features for the WA Cares Fund program over the last 8 years. **Milliman Experiences, Skills, and Qualifications** <u>Rate Setting for State Medicaid Agencies</u> Milliman has vast experience advising states regarding Medicaid Long-Term Services and Supports (LTSS) rate-setting methodologies and related policies. Our team members also have significant experience with	

	the regulatory and compliance considerations for implementing LTSS payment methodologies, as well as decades of experience managing stakeholder engagement (for providers, participants, managed care organizations, and advocates) throughout the rate development process. We also understand LTSS workforce challenges and opportunities facing state agencies and ensuring there are enough workers to meet beneficiaries' needs. In the past five years alone, we have assisted 12 Medicaid agencies, including Arkansas, Hawai`i, Indiana, Iowa, Michigan, Mississippi, New Hampshire, Ohio, Rhode Island, South Carolina, Washington, and Wisconsin with the development of provider fee schedules for LTSS services. We have also assisted with the development of tiered rates for LTSS services in Arkansas, Hawai`i, Indiana, Ohio, Iowa, Rhode Island, and Wisconsin; bundled rates for LTSS services in Indiana and Ohio; and negotiated market rates for LTSS services in Arkansas. As part of these projects, we have also assisted with calculations of cost neutrality, analyzed service utilization, conducted rate development projects, developed innovative managed care rate structures, and projected waiver program expenditures. <u>Actuarial / Financial Modeling for WA Cares Fund</u> Milliman has provided actuarial support and financial analysis and projections for WA Cares Fund since the program was enacted in 2019 (and feasibility studies before the program was enacted). The financial modeling includes the projection of estimated revenue and expenditures under WA Cares Fund for the next 75 years. The expenditures include estimates of service costs incurred by major site of care: nursing home, assisted living facility, and care at home. Our work for WA Cares Fund includes frequent meetings with WA DSHS and WA OSA and various workgroups responsible for recommending / clarifying program features. We also routinely present findings of our work at the LTSS Trust Commission public meetings. <u>Private Market LTC Insurance Service Cost Data</u> Milliman has significant experience in analyzing commercial service costs for Long-Term Care (LTC) Insurance programs. Milliman has developed a set of proprietary Long Term Care Guidelines (*LTC Guidelines*), which provide frequencies, continuance curves, utilization assumptions and claim costs from a large number of product designs over the past three decades. The Milliman *LTC Guidelines* incorporate both private and public sector data sources, and are periodically updated to reflect the most comprehensive and current information available in the market. The *LTC Guidelines* are one area of differentiation from other	

actuarial and consulting firms. The first set of *LTC Guidelines* was developed in 1992 and has been updated regularly, with the most recent edition completed in 2020. The breadth of underlying data and the comprehensiveness of analysis position the *LTC Guidelines* to be an unrivaled benchmark for LTC morbidity.

Milliman Relevant Experience

We list below recent relevant experience that distinguishes Milliman and makes us uniquely qualified to support the work requested under this Contract.

1. Feasibility Studies to Finance LTSS in Washington

Sponsor: Washington Department of Social and Human Services (DSHS)
Project Duration: February 2016 to January 2017, June 2018 to October 2018

In 2016, Milliman was engaged to study the feasibility of offering two unique LTSS financing options in the State of Washington. Various stakeholder interviews and discussions in the State of Washington helped determine the final scope of plan parameters to model for the project. The scope of our engagement included the evaluation and discussion of the following items:

- Expected costs and benefits for participants
- Total anticipated number of participants
- Financial and legal risks to the State
- Savings to the State Medicaid program

In 2018, Milliman was engaged to perform a follow-up study, in which we analyzed the expected costs of changing the plan parameters and sensitivities surrounding these parameters.

2. LTSS Trust / WA Cares Fund Actuarial Studies

Sponsor: Washington Office of the State Actuary (OSA)
Project Duration: February 2020 to Present

After the LTSS Trust Act was passed, Milliman was re-engaged by the OSA in 2020, working closely with WA DSHS, to assist in projecting the current program and modeling program alternatives / changes. Milliman continues to support the development and implementation of WA Cares Fund. Notable deliverables include the 2020 and 2022 Actuarial Study of WA Cares Fund, as well as other deliverables included in the Milliman Actuarial Studies / Reports on the OSA website.

Relevant to this solicitation, our engagement with OSA includes working with a government agency and other stakeholders to analyze LTC financing solutions and has required an understanding of the current LTC financing environment in Washington. Additionally, we gained experience presenting to the LTSS Trust Commission and assisting various legislative work groups.

3. HCBS Rate Study for Washington DSHS

Sponsor: Washington Department of Social and Health Services (DSHS)
Project Duration: June 2022 – Present

Milliman was retained by Washington DSHS to conduct a legislatively-mandated HCBS rate study specific to community residential services for individuals with developmental disabilities. As part of this rate study, the Milliman team coordinated and facilitated key informant interviews with national and state associations (representing providers, state agencies, and HCBS workers), community residential care providers, and clients. We also researched and summarized a multistate comparison of residential care payment rate approaches (with particular focus on behavioral supports), conducted analyses of provider cost report data, and collected staffing and 2022 wage data directly from providers. We have also reviewed a wide variety of HCBS worker wage data and compared wage levels to industries competing for the same workforce. Milliman is currently in the process of developing rate recommendations.

4. Nursing Facility Payment Transformation and Rate Setting for Indiana FSSA

Sponsor: State of Indiana, Family and Social Services Administration (FSSA)
Project Duration: May 2021 – Present

The State's goals for updating Medicaid nursing facility reimbursement were as follows:

- Transition from a fully cost-based reimbursement model to a price-based model that pays for value provided rather than costs incurred.
- Remove retroactive cost settlements and design a prospective-only payment. This was in part needed to facilitate state-direction of the state nursing facility fee schedule to managed care providers.
- Alignment with reimbursement for HCBS and other Medicaid services. The prior reimbursement model, with quarterly updates and guaranteed reflection of any cost increases, was unique to nursing facilities. A level playing field for reimbursement is a key step towards rebalancing.
- Quality – Link provider payments to member outcomes by devoting a material portion of the payment to higher quality facilities and selecting meaningful metrics and relevant metrics on which to base payments.

It was decided at the outset that the reimbursement restructuring would be budget neutral – that is, target total funding in the system would be the same as under the legacy system. This was key to getting provider buy-in. It was understood that there would be "winners and losers", but most were able to support the goal of reallocating funding to reward higher quality and more cost-effective facilities.

The Project was divided into three workstreams:

1. Nursing Facility Base Rates
2. Supplemental Nursing Facility Payments (Upper Payment Limit, supported by IGTs)
3. Restructure Quality Program

For each work stream, the state set up a series of meetings. Milliman prepared materials and led discussion, after first having internal meetings with the State of Indiana to confirm direction and content. We began by presenting background information, including state goals, regulatory constraints, and analysis related to shortcomings of the current system. For example, although there were large differences among the 500+ nursing facilities in per diem reimbursement under the legacy cost-based system, these differences had no statistical correlation with acuity (RUG scores) or quality scores, so it was difficult to justify the variation in payment. We also presented options for the new reimbursement model, offered advantages and

	disadvantages to each, and developed a series of facility-specific models to help stakeholders understand the initial proposal and subsequent refinements, and how it might affect them. Over the course of the project, we worked with the state, nursing facility industry and other stakeholders to build consensus on a new reimbursement structure, supplemental payment design, and quality program. The State also prioritized working collaboratively with stakeholders and agreed to smooth the transition by offering a transition period. Milliman collaborated with the State and stakeholders to model and assess various transition plan options, aiming to strike a balance between introducing the new reimbursement system's goals and minimizing disruption to current operations. Communicating the options and the eventual chosen transition plan clearly to providers was essential to ensuring they had adequate time and information to prepare for the new reimbursement structure. Milliman will continue to provide support to the State and stakeholders as the new system is implemented, ensuring a smooth transition and the successful implementation of the new system as intended. **5. HCBS Rate Setting and Development of MLTSS Quality Framework for Indiana FSSA** Sponsor: State of Indiana, Family and Social Services Administration (FSSA) Project Duration 2019 – Present Milliman is currently supporting a cross-agency effort under Indiana FSSA to establish HCBS rates, working with the Office of Medicaid Policy and Planning (OMPP), the Division of Aging (DA), and the Division of Disability and Rehabilitation Services (DDRS). One challenge with this project is coordinating multiple state agencies and their associated stakeholders through a rate setting process that was aligned, transparent, and towards the conclusion of the public health emergency. We are working with FSSA and the supporting agencies on: • Goal setting and stakeholder engagement planning with the client • Stakeholder engagement throughout the process in an inclusive and transparent framework • Payment methodology, data options, and input • Conceptual design, payment simulation, and refinement • Public comment, state budget and legislative approval, CMS approval	

- Stakeholders (internal and external) were included in project initiation all the way through the final vetting of all rate assumptions.

Related to this work, Milliman also played a stakeholder facilitation role to help the state develop its holistic LTSS quality strategy framework. The state sought to define its quality strategy to inform both its Master Plan on Aging and Medicaid Managed Care Quality Strategy, as well as leverage its purchasing power through specific MCO contract requirements and quality incentives through its upcoming MCO MLTSS procurement. For this project, we have conducted an extensive environmental scan and research, followed by a series of stakeholder interviews (meeting with over 30 leaders across multiple agencies) to understand available data and performance measures, historical and recent performance including performance gaps, external stakeholder input received to date and other pertinent insights about the current landscape. We then facilitated a strategy session summit where we helped the group to establish a set of guiding MLTSS Quality Framework goals. Follow-up activities included working with a subgroup to establish foundational Year One objectives and metrics to monitor progress toward the goals. We also assisted with the development of managed care RFP language to outline the quality strategy and outline plan responsibilities to achieve the goals and objectives.

6. Residential Care and Behavioral Health Rate Setting for Michigan DHHS

Sponsor: Michigan Department of Health and Human Services
Project Duration: 2019 – Present

Milliman was retained by Michigan DHHS to provide actuarial and consulting services related to the development of a behavioral health and intellectual/developmental disabilities (BH I/DD) fee schedule for its specialty services managed care program (Note: MDHHS includes both BH and I/DD services in this program, which is often referred to as their Behavioral Health Program). This BH I/DD fee schedule was a system-wide project spanning multiple years and encompasses a wide range of services that are covered under the managed care capitation rates, including case management and treatment planning, community living supports, evaluation and management, outpatient services, psychiatric diagnostic evaluations, residential services, and skill building. Milliman is also supporting the development of tiered residential care payment rates for individuals with I/DD and individuals with serious mental illness. Milliman has facilitated a

	stakeholder workgroup to obtain feedback on tiering approaches, conducted provider interviews to obtain insights on residential care staffing and service delivery, conducted research on other state approaches, and performed an analysis of SIS-A assessment data to assess the relationship between SIS scores and HCBS service utilization. **7. HCBS Rate Setting and Stakeholder Support for Ohio DODD** Sponsor: Ohio Department of Developmental Disabilities Project Duration: 2022 – Present Milliman was retained by Ohio DODD to support the development of HCBS payment rates and the design of a quality program for Adult Day and Employment services for individuals served by the Department of Developmental Disabilities (DODD). Our team is currently working with stakeholders to establish HCBS rates that consider historical and future wages for HCBS providers and the potential downstream impact on services that are outside of the rate study. We have also been facilitating engagement with key stakeholders to solicit input and support regarding the implementation of two quality programs, which will include an ARPA supported pilot, capacity/infrastructure payments, and outcomes-based payments. **8. Provider Rate Review for Rhode Island OHIC** Sponsor: Rhode Island Office of the Health Insurance Commissioner Project Duration: 2023 – Present Milliman is currently engaged by Rhode Island OHIC to provide a comprehensive review of health and human services offered in the state, including both a financial and programmatic assessment. The financial assessment includes review of program rates, timing of last rate increase, utilization trends, and comparisons between Rhode Island and other regional states on these topics. Programmatic review includes assessment of eligibility standards, processes of program operations, access to programs, organizational structure, oversight of program providers, and accountability structures, including all programs funded by Medicaid and other funding sources in the following areas: social, mental health, aging, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative,	

	substance use disorder treatment, residential care, adult or adolescent day services, employment and training, and vocational services. This work is overseen by the Office of the Insurance Commissioner and an advisory council created for this purpose and includes a series of legislative reports summarizing the findings. Our work includes both conducting the independent research needed to provide full assessment and collaboration with the advisory council and other invested stakeholders. Our programmatic research has involved review of state administrative regulations, state program documents and web pages and applying our knowledge of federal regulations and processes. Drawing on Milliman's expertise across the array of programmatic areas has allowed us to narrow focus to the most critical components of programming in each sub-population and provide the critical assessment required to bring meaningful insights and note best practices and perhaps areas that are ripe for improvement. This financial work likewise, has required the application of Milliman's rate setting expertise and coordination with state agencies on rate information that is not within the public domain. **9. Rate Updates and Alignment for Mississippi Division of Medicaid** Sponsor: Mississippi Division of Medicaid Project Duration: July 2011 - Present As the consulting actuary for the State of Mississippi, Milliman routinely assists the Division to update the FFS rates for the HCBS waiver programs. Examples of services for which rates have been developed include attendant care, assisted living, adult day care, autism services, and case management. The modeling approaches vary depending on the service but generally involves a "ground-up" build using wage and benefit data, productivity assumptions, industry staffing ratios, and related administration costs for the services provided. In certain situations, other ancillary services such as transportation were incorporated. Stakeholder engagement has been a key part of each of the rate updates, consisting of survey tools, workgroups, and other feedback mechanisms.	

	Currently Milliman is assisting the state with a full rebasing of all fee schedules for the assisted living, community support program, elderly disabled, intellectually and developmentally disabled, independent living, and traumatic brain injury waivers.	
B	Please provide the names of the key team members you will assign to this Contract, if you are the Successful Bidder, and provide their proposed roles and copies of resumes describing the relevant experience they possess. Bidder should note that if awarded a contract, it may not reassign its key personnel from the Project without prior approval of DSHS.	10
	ANSWER: Key personnel proving assistance on the project are outlined below. **Chris Giese, FSA, MAAA** Project Role: Overall Project Responsibility and Primary Project Contact Chris Giese, FSA, MAAA, is a Principal and Consulting Actuary. He joined the firm in 2000. Chris has experience with healthcare and long-term care programs, with more than 20 years of experience in these areas. Chris has worked on various projects supporting the State of Washington and the WA Cares Fund since 2016. Chris has assisted various entities, including insurance companies, health plans, employers, technology firms, and government programs. He has helped clients with a wide variety of projects such as financial projections and reporting, valuation of reserves, experience analysis, product development and pricing, appraisals, risk management, and evaluations of financing reform alternatives. Chris previously served as Chair of the Society of Actuaries (SOA) LTC Section Council and participated in various SOA and American Academy of Actuaries work groups. Most recently, Chris led projects gathering stakeholder feedback and analyzing various policy options to alternatively finance LTC for the states of Washington, California, Illinois, and Michigan. Chris has assisted LTC insurance carriers with evaluating the adequacy of active life reserves and claim reserves, performing	

	in-depth analysis of historical morbidity and persistency experience for various blocks of business, completing annual statements of actuarial opinion regarding insurance companies' statutory / GAAP liabilities, and helped a company develop framework and projections to illustrate LTC costs in retirement planning for consumers. In addition to LTC programs, Chris has assisted healthcare program including supporting benefits administration firm to develop cost estimates used in helping employees decide among plan options during open enrolment, performing comprehensive analysis for employer on quarterly basis to identify and prioritize individuals for proactive outreach as part of its population health management, measuring healthcare costs versus regional and national benchmarks, and assisting entities in developing a multi-year strategic plan in response to the Affordable Care Act. Chris is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He holds a B.S. in Mathematics from Carroll College. **Luke Roth** Project Role: Senior Healthcare Consultant and Secondary Project Contact Luke Roth is a Principal and Senior Healthcare Consultant in the Seattle office of Milliman. He rejoined the firm in 2018. Luke has over 15 years of experience providing strategic guidance and transformative solutions to healthcare leaders and policy makers as they have navigated the unique risks and opportunities facing their organizations. As a member of Milliman's Medicaid Finance and Policy practice, he primarily supports state agencies in the areas of: • Long-term services and supports (LTSS) payment system design and rate setting, including nursing home services and home- and community-based services. • Hospital inpatient and outpatient payment system design and rate setting, including inpatient DRG-based payment systems, outpatient EAPG-based payment systems, and outcomes-based incentive payments.	

- Medicaid program funding strategies, including development and implementation of health care-related taxes, intergovernmental transfer (IGT) programs, and certified public expenditure (CPE) programs.
- Supplemental payments strategy, including development and implementation of FFS supplemental (UPL) payments, managed care pass-through payments, state directed 438.6(c) payments, uncompensated care pool (UCP) payments, and disproportionate share hospital (DSH) payments.

Within the past year, Luke has provided provider payment policy and rate setting support to state agencies in Arizona, Illinois, Nebraska, Oklahoma, Florida, and Washington. He also recently co-authored a whitepaper with ADvancing States, the association representing the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors, on strategies to address challenges related to financing for nursing facility services during MLTSS program implementation.

Luke holds a bachelor's degree in Mathematics from the University of Washington.

Jill Bruckert, FSA, MAAA
Project Role: Senior Medicaid / LTC Consultant and Secondary Project Contact

Jill Bruckert, FSA, MAAA, is a Principal and Consulting Actuary. She joined Milliman in 2007 and has spent her career providing actuarial support and consulting services to state Medicaid agencies, governmental organizations, and Medicaid health plans. In addition, Jill has experience providing strategic and actuarial services to LTC insurance companies and has been involved in LTC reform analyses.

Jill has worked extensively with state Medicaid agencies to develop and certify acute care and LTC managed care capitation rates, develop HCBS and behavioral health fee schedules, budget analyses and expenditure projections, custom risk adjustment methodologies, waiver support, legislative studies and fiscal impact analyses, and many other ad hoc projects.

Relevant to this solicitation, Jill has led developing fee schedules for HCBS and behavioral health services in the state of Mississippi since 2015, including a current project to rebase all HCBS fee schedules.

	Jill is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She holds a bachelor's degree in Actuarial Science and Finance from the Drake University. **Annie Gunnlaugsson, ASA, MAAA** Project Role: Oversee Calculations and Deliverable Development Annie Gunnlaugsson, ASA, MAAA, is a Consulting Actuary. She joined Milliman in 2012. Annie has served many types of clients in her time with Milliman. Her areas of focus include LTC insurance and the group and individual commercial health markets. Annie has worked on various projects supporting the State of Washington and the WA Cares Fund since 2016. Annie has assisted clients in the areas of ACA pricing and rate filings, year-end statements of actuarial opinions, state insurance department LTC rate filings, and reserve estimation for medical and long-term care products. Most recently, Annie helped assist in projects analyzing various policy options to alternatively finance LTSS for the states of Washington, California, Illinois, and Michigan. Annie is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. She holds a bachelor's degree in Actuarial Science from the University of Wisconsin Madison. **Evan Pollock, FSA, MAAA** Project Role: Lead Technical Calculations Evan Pollock, FSA, MAAA, is a Senior Actuarial Manager. He joined Milliman in August 2015. Over the past eight years, Evan has focused on three main market areas: LTC insurance, Medicaid, and group and individual commercial health insurance. Evan has worked on various projects supporting the State of Washington and the WA Cares Fund since 2020. Evan has worked on projects ranging from pricing, reserving, and experience review to feasibility studies, capitation rate setting, and options analysis. Recently, his focus has been private LTC insurance, LTC reform, and Medicaid LTC rate development for a large state client. Relevant to this solicitation, Evan helped assist	

	in projects analyzing various policy options to alternatively finance LTSS for the states of Washington, California, Illinois, and Michigan. Evan is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He holds a bachelor's degree in Actuarial Science from the University of Wisconsin Madison. **Jennifer Gerstorff, FSA, MAAA** Project Role: Peer Review and Support with WA Medicaid Program Jenny Gerstorff, FSA, MAAA, is a principal and consulting actuary with Milliman's Seattle office. She joined the firm in 2006. Jenny has spent her entire actuarial career working primarily with state Medicaid agencies, working on programs in over half of the states across the years. With a wealth of experience in Medicaid actuarial and policy consulting, Jenny specializes in working closely with state Medicaid agencies on a diverse range of critical topics. Her extensive expertise encompasses capitation rate development, new policy feasibility analysis, program integrity monitoring and improvement, state budget forecasting, healthcare delivery system integration, customized risk adjustment, health disparity evaluations, risk mitigation mechanisms, and encounter data monitoring. Jenny's proficiency extends across various benefit types, including Medicaid acute care, community behavioral health, long-term care, dental, and other ancillary benefits. She has also worked with a wide array of populations, including traditional Medicaid, ACA Expansion adults, Medicare-Medicaid dual-eligibles, non-qualified non-citizen expansions, and other specialized program populations. Beyond her work with state Medicaid agencies, Jenny has been a trusted consultant to independent provider organizations, non-national health plans serving Medicaid and Medicare populations, Medicaid health plan associations, and safety net healthcare providers. Her extensive background includes conducting financial and utilization-based analyses to support the development of historical experience studies, proforma projections, risk mitigation strategies, provider reimbursement rates, grant funding applications, and value-based contracting model implementation.	

	She volunteers with the Society of Actuaries (SOA) and the American Academy of Actuaries (AAA), participating in research efforts and developing content for continuing education opportunities for over a decade. In 2022, Jenny was appointed as a commissioner at the Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan government advisory body that plays a pivotal role in shaping Medicaid and CHIP policy through its guidance and recommendations to policymakers. Jenny is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She holds a B.S. in Applied Mathematics from Columbus State University.	
C	Please describe your method for assuring that your services and deliverables are provided in accordance with high quality standards and for immediately correcting any deficiencies. What data would you propose to report to DSHS which would permit verification of your quality assurance activity, findings and actions?	20
	ANSWER: Milliman employs a strong ethic of peer review in all its projects. This process requires a secondary review of the work performed, reports prepared, and overall project management. The reviewer is selected as someone familiar with the project, but who has not performed significant work on the specific project. This allows for impartial review and the opportunity for additional insights. The review is structured to identify any outstanding issues that were not addressed, to ensure that the information is presented in a logical and complete manner, and to ensure that the overall quality of the work meets Milliman's high standards. This process adds an additional level of security for our clients. Should any deficiencies be discovered, we will work together with the State to ensure concerns are addressed in a timely manner. Accuracy and client satisfaction are our highest priorities in any engagement. At the individual client level, we tailor our procedures to your needs. Our consultants monitor client satisfaction through various informal contacts (e.g., in-person, virtual) on a continuous basis. Our high client retention ratios attest to the satisfaction of our clients.	
D	Please describe the measures you employ to assure that your services and deliverables are provided in a cost-effective manner that is consistent with quality outcomes and fair employment practices.	20
	ANSWER:	

	Our fees reflect the estimated actual time spent on a project and related expenses. Our work is completed at the lowest hourly billing rate level possible while still providing the expertise required by our clients. Thus, technical work is often completed by analysts. Alternatively, planning, project design, assumption setting, and peer review are completed by more experienced consultants.	
E	Please provide a work sample of a like project completed in the past that demonstrates the gathering of data necessary to evaluate current rates, potential rate fluctuation and/or a study demonstrating a similar data and study structure. Please include all work samples in a single PDF attachment. Submissions received in alternate formats may not receive a score. *Please ensure all proprietary material is clearly marked in accordance with RFP Document Section D.5.*	50
	ANSWER: Please see "RFP2334-830_Supplement D.5.e - SD1_Rate Study.pdf" for a work sample.	
F	Please provide a narrative explaining how you plan to complete this project, inclusive of a proposed timeline in alignment with the deliverables table in the RFP and sample contract.	50
	ANSWER: The focus of our engagement will be to provide guidance on how to utilize, maintain, and update rates as WA Cares program experience emerges. We will provide considerations and data points to assist WA Cares Fund in developing a structure for adapting to a dynamic marketplace for long-term care services. Below we provide a work plan for achieving these goals. **Data Collection** Between October 2023 and January 2024, we will largely focus on data collection and summarization. Specifically, we plan to gather information on current and historical rates for the LTSS service categories outlined in the solicitation for this engagement. The sources will vary for each applicable service, but in general we expect to leverage the following data sources.	

- **Washington Medicaid data** provided by the State of Washington (e.g., utilization of services and rates paid out to providers in Medicaid LTSS). This data will inform Medicaid rates for many of the WA Cares Fund services. We will supplement with CMS Transformed Medicaid Statistical Information System (T-MSIS) data if applicable.
- **Milliman proprietary databases**, namely the Long-Term Care Guidelines Database, which includes data from the commercial market, and the Consolidated Health Cost Guidelines Sources Database, which covers other lines of business. These sources represent tens of millions of life years of claim experience and will provide another benchmark for the major WA Cares Fund services.
- **Public sources**, including the Genworth cost of care survey, Bureau of Labor Statistics, review of reports / literature of LTSS service costs, etc. Genworth's cost of care survey is published publicly on an annual basis and contains information about average costs of care by service and geographic region for a commercial population. We will perform a thorough search for other relevant publicly available information to estimate and project average LTSS costs for the applicable population.
- **Other interviews and surveys** of long-term care providers. We will work with DSHS to determine if conducting a new interview or survey of LTSS providers in Washington is a worthwhile endeavor as part of this study (i.e., weigh the costs and benefits of gathering information from this particular channel). If an interview or survey is determined to be worthwhile, Milliman will provide guidance and support to DSHS on how to conduct the interview and survey. Once interview and survey responses are collected by DSHS, Milliman will compile and analyze the results.

Study Analysis

Analysis of the collected information will be both quantitative and qualitative.

From a quantitative perspective, we will use gathered data to produce rate ranges by service category and project how those ranges may change over time (e.g., be adjusted for inflation). Given the detailed models we already have created to project WA Cares Fund cash flows, we can also perform quantitative analysis on how different rates may impact projections of the financial outlook of the program.

	From a qualitative perspective, we will leverage our expertise in LTC, Medicaid, and the WA Cares Fund to advise on rate-related topics such as: • Policy options for the rates and how the rates can be utilized by various stakeholders. • How reimbursement for these services may impact provider availability. • Guidance on how DSHS can adapt to maintain appropriate reimbursement as WA Cares program experience emerges. **Presentation of Findings** Between January 2024 and August 2024, we will develop focused reports for each project phase (1 through 4) that will provide the following information: a) Results from our qualitative and quantitative analyses. b) Methodology and assumptions used in our study. c) Considerations for engaging with the results and guidance on next steps for the program. Our work will culminate with a final report before May 2025. Throughout the engagement we will provide needed expertise, guidance, education, and consultation to support WA Cares Fund staff, stakeholder groups, and the LTSS Trust Commission in areas associated with this Contract and attend ongoing meetings with these groups as is helpful.	
G	Please describe current or prior projects that demonstrate a like process and product. Please explain challenges and how they were overcome. Where do you foresee similar or different challenges with this study?	20
	ANSWER: We list below projects that demonstrate our experience and challenges encountered for analyzing rates. We see similar challenges for this study, but expect the framework used to complete prior projects and	

	overcome any challenges will also be effective for conducting this study. We expect this study will face new challenges since the WA Cares program is first-of-its-kind with no direct program experience to use for obtaining data. We expect some service categories will have more robust data to analyze (pulling from existing public and private program experience), while other categories may have very limited data to analyze. We envision our final deliverable for the study will establish a process for overcoming these challenges, including considerations of how to reflect actual program data as it emerges. **Current / Prior Projects with Like Process and Product** Milliman has assisted numerous state Medicaid agencies and other entities with the design, implementation, evaluation, and monitoring of payment systems and rate-setting methods for all types of services: • Long-term supports and services, including nursing facility services, residential services, and other HCBS provided to the aged and disabled populations, as well as to persons with intellectual or developmental disabilities. • Behavioral health services, including HCBS and other services that are unique to persons requiring these services, such as partial hospitalization, intensive outpatient and substance use disorder services • Inpatient and outpatient hospital services, including acute services, both short-term psychiatric care and long-term civil commitment services, rehabilitation, long-term acute care, and other types of hospital settings • Professional and clinic services, including physician, nursing, therapy, and other services • Other unique services provided by state Medicaid agencies, including services provided under authority granted through CMS waiver programs With respect to rates for long term services and supports, Milliman understands the challenges and opportunities facing states like Washington as they develop public policy that impacts payment for and access to long-term services and supports, which can have implications for individuals receiving these services to live healthy, safe, meaningful, and self-determined lives that include the ability to fully engage in community living.	

	Milliman recently assisted the Washington State Health Care Authority (HCA) with developing comparison rates intended to provide transparent benchmark estimates of Medicaid payment rates to providers for behavioral health services, using methodologies consistent with CMS approved HCBS rate structures. These comparison rates comprise all significant behavioral health services, including mental health and substance use disorder (SUD) outpatient services and SUD residential care and withdrawal management. The Milliman team used an independent rate model approach consistent with methodologies used for HCBS payment, informed by analyses of independent data sources (e.g., Bureau of Labor Statistics wage data), and State program staff and provider subject matter expertise. Milliman developed and implemented a stakeholder engagement strategy including all-provider meetings, three stakeholder workgroups (specific to service type) and ad hoc subgroups for intensive team-based services for adults and youth. Rate assumptions include the identification of wage levels by type of behavioral health professional, employee-related benefits and taxes, supervisor span of control, turnover, training, paid time off, administrative costs, transportation, residential facility staffing, and facility overhead costs, among others. Community residential agencies are facing immense pressures, ranging from workforce competition to making sure that services are person-centered. These unique business challenges that providers face can primarily be grouped into two buckets, which can sometimes overlap: financial challenges and service challenges. **FINANCIAL CHALLENGES** Community residential agencies require sufficient rates to hire and maintain a skilled workforce that is able to deliver person-centered services. Per a 2019 Report to the Legislature, *Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers, and Improve Services*, "Feedback from contracted providers consistently indicates that they are unable to recruit and retain sufficient numbers of skilled direct care professional under the current rate." Financial pressures have only increased since 2019 due to the pandemic, workforce competition, and the global financial landscape. Below are considerations of key financial challenges that providers are facing. **Wage pressures and staff retention**	

	Washington, like many states, faces challenges supporting residential care workforce recruitment, training, development, and retention. Community residential agencies will face challenges building a high-quality workforce that is able to provide continued access to services with high turnover and vacancy rates. High turnover and vacancy rates not only impact the delivery of services to clients, but also leads to higher costs to providers as they spend more time on training, getting staff oriented with their job duties, and longer service time as they build a relationship with their clients. Milliman brings an in-depth understanding of the workforce challenges that states face when ensuring access to high-quality services, which have been exacerbated by the COVID-19 pandemic's impact on the economy. We regularly gather feedback from stakeholders regarding state-specific labor market dynamics and wage levels and have extensive experience collecting and analyzing a wide variety of national and state wage data when developing payment rates. This experience includes developing and administering state-specific cost and wage surveys that identify wages by staff level and employee-related benefit costs and conducting stakeholder interviews. We also work with states to address workforce challenges more broadly. For example, in Rhode Island, we are supporting the State in the implementation of a temporary increase in Medicaid fee-for-service rates with specific requirements to pass the extra funds through to direct care workers in the HCBS provider organizations, while in Florida we conducted an assessment of the state's increased minimum wage and its impact on reimbursement rates for HCBS providers and residential care facilities among others. Our support to our clients has included identifying included providers, drafting program guidance, assisting in stakeholder meeting facilitation, and researching policy alternatives consistent with regulatory guidance and operational needs. **Additional challenges** In addition to minimum wage adjustments, providers are feeling wage pressures due to inflation, demand for services, and the public health emergency for COVID-19. Some of these wage pressures are temporary and will be replaced by other pressures. As such, payment rates must be flexible and transparent to incorporate mid-stream adjustments to account for these unanticipated pressures.	

SERVICE CHALLENGES

Community residential agencies are adapting to evolving service requirements as states are moving towards paying for outcomes, providers are complying with the HCBS Setting Rule, and temporary service standards implemented during the pandemic are becoming permanent (e.g., virtual service delivery). Below are considerations of key service challenges that providers are facing:

Compliance with HCBS Setting Rule

Providers must follow the requirements of the HCBS Setting Rule (under 42 CFR § 441.301(c)(4)(5) and § 441.710(a)(1)(2)) by providing integrated service options and both choices and rights within a residential setting (e.g., choice of a private room, roommate, schedule, etc.) Residential providers must not only comply with these requirements but must also report their compliance to Residential Care Services (RCS) Contracted Evaluators and RCS Investigators. Providers must continue to emphasize and train their staff on person-centered care planning that supports a person's choice and preferences.

Quality and outcomes reporting

States are requiring the delivery of and outcome and quality reporting to support the delivery and payment for services, especially as states are reinforcing person-centered services and meeting the requirements of the HCBS Settings Rule. Providers, and their direct support professionals, need to learn how to report outcomes and quality measures. These reporting requirements can increase both indirect service time and administrative costs for providers, as well as payments, if quality and outcomes reporting is tied to payments.

Culturally specific services

Washington is a geographically and culturally diverse state, which can cause challenges with delivering person-centered services that are impactful and meet the needs of an individual. Community residential agencies will need to hire and retain staff that can build relationships and deliver services with people that

	may be non-verbal, speak languages other than English, suffer from homelessness, are Indian tribal members, have dual-diagnoses and require mental health services, or some other need that will require the support of a workforce that is responsive to an individual's values, beliefs, health literacy, preferred language, and other communication needs. Providers are facing challenges building a workforce that is able to deliver culturally specific services, and in a language that a person can understand, which requires a tenured workforce that is appropriately trained and can build relationships with the people they serve. Hiring and retaining culturally specific practitioners will require a provider to pay a premium wage to retain a direct care provider that can deliver culturally specific services.	
H	Please provide an explanation of methodologies and strategies while gathering necessary data for this project.	20
	ANSWER: We will work with DSHS to determine if conducting a new interview or survey of LTSS providers in Washington is a worthwhile endeavor as part of this study. Obtaining data through a survey process is one of the common strategies we use when conducting rate studies and developing rate recommendations. We often rely on surveys to collect additional information and data from stakeholders that will provide important insights in the process. Milliman staff have extensive experience in designing and administering surveys, reviewing the information reported, and processing and analyzing the data received. Conducting interviews and workgroup meetings with stakeholders is another common strategy for collecting information to consider when conducting rate studies and developing rate recommendations. Our staff also have experience in conducting interviews and interactive meetings with various stakeholders to gather important feedback and information, and to better understand the challenges faced by stakeholders. As an example, Milliman was recently retained by Washington DSHS to conduct a legislatively-mandated HCBS rate study specific to community residential services for individuals with developmental disabilities. As part of this rate study, the Milliman team coordinated and facilitated key informant interviews with national and state associations (representing providers, state agencies, and HCBS workers), community residential care providers, and clients. We also researched and summarized a multistate comparison of residential care payment rate approaches (with particular focus on behavioral supports), conducted analyses of provider cost report data, and collected staffing and 2022 wage data directly from providers. We have also reviewed	

	a wide variety of HCBS worker wage data and compared wage levels to industries competing for the same workforce.	

6	**BUDGET AND REPORTING**	**MAXIMUM 10 TOTAL POINTS**
A	Please complete Attachment F: Budget Response Template, detailing all costs to provide the services as outlined in this Competitive Solicitation, including the Sample Contract set forth on Attachment A. Please include the completed form as a separate document in your bid response. Please provide a general budget narrative below that describes in detail how the budget will be associated with benchmarks and deliverables referenced in Section A(7) of the solicitation document.	10
	Bidders are to complete the Attachment F: Budget Response Template spreadsheet and submit it in Excel format with your bid response. Your responses in Attachment F will be scored in this section of Attachment D: Bidder Response Form. ANSWER: Please see "RFP2334-830_Attachment_F_Budget Template_Milliman_20230929.xlsx" for our completed Budget Response Template spreadsheet. Our professional fees will be based on the actual hours worked on the project multiplied times our consulting fee hourly rate, subject to the total maximum amount under this solicitation. The 'Consulting Fees for Professional Services' line item in Attachment F reflects all estimated costs to perform the services under this engagement. We include in the table below how the budget will be associated with benchmarks and deliverables referenced in Section A(7) of the solicitation document. The estimated budget by deliverable / benchmark is based on the number of estimated hours and resulting professional fees to complete each task, subject to the overall total maximum amount under this solicitation.	

		Deliverables and Benchmarks	Estimated Budget		
		Introductory Meeting	**$25,000 upon completion of service group 1**		
		Check-in and DSHS Approval			
		Data Share Agreement			
		Service Group 1 Meetings			
		Service Group 1 Rate Recommendations Report and DSHS Approval			
		Service Group 2 Meetings	**$25,000 upon completion of service group 2**		
		Service Group 2 Rate Recommendations Report and DSHS Approval			
		Service Group 3 Meetings	**$25,000 upon completion of service group 3**		
		Service Group 3 Rate Recommendations Report and DSHS Approval			
		Service Group 4 Meetings	**$25,000 upon completion of service group 4**		
		Service Group 4 Rate Recommendations Report and DSHS Approval			
		Inflation Adjustment Meetings	**$25,000 upon completion of report**		
		Inflation Adjustment Methodology Report and DSHS Approval			

7	**BIDDER'S PROPOSED PRICING (QUOTATION OR COST RESPONSE)**	**MAXIMUM 5 TOTAL POINTS**
A	Please identify all allocated costs, together with the total charges Bidder is willing to accept in consideration of the full performance of the Contract.	**5**
	ANSWER: TOTAL MAXIMUM BID AMOUNT: $125,000	
B	Please fully describe any assumptions Bidder has made that affect its proposed total charges, if those assumptions are not explicitly addressed in Attachment A, Sample Contract.	**NOT SCORED**
	ANSWER:	

	The maximum bid amount was developed by estimating anticipated hours to complete each task for this study multiplied by our consulting fee hourly rate for the key personnel and supporting staff anticipated to support this engagement. The estimated hours are based on the work plan outlined in D.5.f. We capped overall fees to not exceed the total maximum amount under this solicitation.	

Attachment E
Contractor Inclusion Plan

Instructions

DSHS requires that bidder submit this inclusion plan template as part of their proposal. Once submitted, the Inclusion Plan template becomes part of the contract if awarded to the bidder. The Bidder shall also include an anticipated list of small and diverse subcontractors or vendors who may provide services on the project. Responses should reflect the Bidder's sincere efforts to include diverse small businesses. Businesses listed in the plan must be certified by OMWBE or DVA, or registered in WEBS as a small business. If a company is not certified or registered but may be eligible for certification, the Bidder should encourage the company to become certified.

Inclusion goals are aspirational. No preference is given for inclusion plans or goals in the evaluation of bids. While no minimum level of OMWBE certified, Veteran Owned, or Washington Small Business participation will be required as a condition for receiving an award, the plan must include the actions the contractor will take to increase subcontracting opportunities for those business types.

DIVERSE BUSINESS INCLUSION PLAN

1. Do you anticipate using, or is your firm, a Washington State Certified Minority Business?

   ☐YES ☒NO

2. Do you anticipate using, or is your firm, a Washington State Certified Women's Business?

   ☐YES ☒NO

3. Do you anticipate using, or is your firm, a Washington State Certified Veteran Business?

   ☐YES ☒NO

4. Do you anticipate using, or is your firm, a Washington State Small Business?

   ☐YES ☒NO

5. If you answered No to all the questions above, please explain:

   Milliman is not a certified Washington State diverse-owned or small business, but we are committed to diversity efforts. Although we are not a certified Washington State diverse-owned or small business, we monitor workforce diversity data throughout the world and use the information internally to monitor and measure our progress and adapt policies accordingly. That data includes gender and age group, and may include ethnicity, disability, and veteran status, depending on geography. Milliman collects employee

diversity data through voluntary self-reporting during the onboarding process and discloses demographic information on a need-to-know basis to our clients.

Given the scope and budget for this project, we plan to perform the work included in this engagement without any subcontractors.

6. A description of your firm's planned efforts at outreach to the small and diverse business community:

   Milliman is not a Washington State certified diverse-owned or small business, nor do we plan on using any subcontractors meeting the Washington State certifications for the purposes of this engagement given the project scope and budget. For potential future engagements and follow-up work, we would involve a subcontractor from the small and diverse business community when the scope and required expertise fits for a particular project, as we have with previous work (see question #7).

   In June of 2023, Milliman hired our first Director of Procurement who will partner closely with our Chief Sustainability and DEI Officer and the Director of Social Impact and Sustainability to direct a vendor management program. Currently, Milliman does not track nor solicit diversity statuses or credentials for our supply chain in a centralized fashion. However, multiple business units within the firm do actively engage in formal supplier diversity actions, localized to their business units. With this partnership, we look forward to expanding supplier diversity actions firm-wide, and driving a program to meet critical supplier diversity needs and goals. More information is available by emailing socialimpact@milliman.com.

7. A list of projects (5 max.) with diverse business participation in the last five (5) years:

Subcontractor	**Project**	**Year**	**Percentage**
ET Consulting LLC (small business, woman-owned)	Assisted the Federal government with review of LTC plan offerings.	2022-2023	25%
ET Consulting LLC (small business, woman-owned)	Feasibility study of policy options to finance LTSS in the State of Washington, prepared for the Washington Department of Social and Health Services.	2016-2017	6%

8. A description of how firm considers small business in the development of bid packages.

Milliman is not a Washington State certified small business. We evaluate the use of small business contractors on a project basis depending on the project scope and budget. For potential future engagements and follow-up work, we would involve a subcontractor from the small and diverse business community when the scope and required expertise fits for a particular project, as we have with previous work (see question #7).

9. Describe the actions you will take to increase subcontracting opportunities for those business types.

   See response to question #6.

10. Please indicate the number of people in your Diversity Inclusion team.

    At Milliman, all employees must complete engage in diversity and inclusion activities, including annual anti-harassment and anti-discrimination training. We also provide focused DEI training to our employees on topics such as unconscious bias and understanding how biases creep into the recruitment/interviewing process throughout the employee lifecycle. We are currently updating our management and leadership training to focus specifically on ensuring equity in hiring, assigning work, performance discussions, and promotions.

    At the executive level, our senior leadership team (CEO and direct reports) includes ethnic minorities and women. A Chief Sustainability and DEI Officer, Dr. Christal Morris, joined the firm September 2022. Our DEI Committee reports to the Milliman Board of Directors. The mission of the committee is to continue to expand efforts to create an inclusive culture throughout Milliman by listening to our employees, creating a shared understanding of the importance of a diverse and inclusive workplace, and providing the infrastructure to educate, evolve, and measure our progress.

If you answered Yes to any of questions one through four, please complete questions eleven through thirteen.

11. Please list the approximate percentage of work to be accomplished by each group in this contract:

    11.1 Minority [INSERT #]%

    11.2 Women [INSERT #]%

    11.3 Veteran [INSERT #]%

    11.4 Small Business [INSERT #]%

12. Please identify the person in your organization to manage/ lead your Diverse Inclusion Plan responsibility.

    12.1 Name:

    12.2 Phone:

    12.3 E-Mail:

13. Please identify the list of potential diverse subcontractors

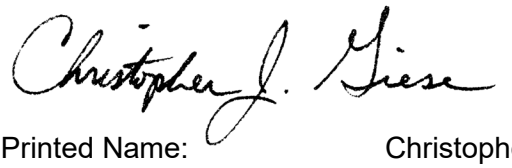
    13.1 ----------

    13.2 ----------

13.3 ----------

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

Bidder's Signature:



Printed Name:	Christopher J. Giese
Title:	Principal and Consulting Actuary
Organization Name:	Milliman, Inc.
Date:	September 29, 2023
Place Signed (City, State):	Brookfield, Wisconsin

Supplement D.1.d
Response to Attachment D, Section 1, Item d
Exceptions to the Washington Department of Social and Health Services'
RFP#2334-830 Sample Contract

The submission of this proposal in response to the RFP may constitute Milliman's acceptance of DSHS' contract terms should the changes to the provisions below, or the addition of the new provisions below, be accepted. Milliman shall not be bound by any contract terms or obligated to perform the services described in this proposal until a mutually acceptable written agreement is signed by the parties.

Section	Exception
DSHS General Terms and Conditions, Section 11	The Contractor shall, at no cost, provide DSHS and the Office of the State Auditor with reasonable access to Contractor's place of business, Contractor's records, and DSHS client records, wherever located, upon reasonable advance written notice […]
DSHS General Terms and Conditions, Section 16(c)	DSHS may immediately terminate this Contract by providing thirty (30) days' prior written notice to the Contractor […]
DSHS General Terms and Conditions, Section 23(a)	The Contractor shall be responsible for and shall indemnify, defend, and hold DSHS harmless from any and all claims, costs, charges, penalties, demands, losses, liabilities, damages, judgments, or fines, of whatsoever kind of nature, arising out of ~~or relating to a)~~third party claims stemming from the Contractor's gross negligence, fraud or willful misconduct in its~~or any Subcontractor's~~ performance of the services under~~or failure to perform~~ this Contract, or b) allegations that the work product provided by Contractor, including an pre-existing internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates incorporated into such work product by Contractor, to DSHS infringes said third party's intellectual property rights~~the acts or omissions of the Contractor or any Subcontractor~~.
DSHS General Terms and Conditions, Section 23(b)	The Contractor's duty to indemnify, defend, and hold DSHS harmless from any and all third party claims […]

DSHS General Terms and Conditions, Section 31	The CCLS Chief may ~~immediately~~ terminate this Contract for default, in whole or in part, by providing thirty (30) days' written notice and an opportunity to cure to the Contractor if DSHS […]
DSHS General Terms and Conditions, Section 32(c)	Upon failure to return DSHS property within ten (10) calendar days, the Contractor shall be charged with all reasonable costs of recovery, including transportation. Notwithstanding the foregoing, the Contractor may retain one copy of the DSHS property for purposes of complying with its internal archival and records retention policies, subject to the Contractor's continued compliance with the confidentiality and non-use restrictions set forth in this Agreement.
Special Terms and Conditions, Section 4 (b)	[…] withhold payment claimed by the Contractor for services rendered if Contractor fails to satisfactorily comply with any term or condition of this Contract. Contractor reserves the right to suspend its performance hereunder if any undisputed sums owed to it go unpaid for more than sixty (60) days.
Special Terms and Conditions, Section 5(h) (Insurance)	The Contractor shall submit a copy of the Certificates of Insurance to DSHS for each coverage required of the Contractor under the Contract. The Contractor shall submit the copies of the Certificates of Coverage to Central Contract Services, Post Office Box 45811, Olympia, Washington 98504-5811 or CCSContractsCounsel@dshs.wa.gov. Each copy of Certificate of Insurance shall be executed by a duly authorized representative of each […]
Special Terms and Conditions, Section 5(i)	[…] written notice of cancellation or non-renewal of any insurance policy required under this Contract to the extent such cancellation or non-renewal would cause Contractor to be noncompliant with the requirements of this Section.
Special Terms and Conditions, Section 5(j)	Contractor waives all rights of subrogation against DSHS for the recovery of damages to the extent such damages are or would be covered by Contractor's Commercial General Liability insurance required under the Contract.
Special Terms and Conditions, Section 5(l)	~~All~~ Contractor's Commercial General Liability insurance provided […]
Special Terms and Conditions, Section 6 (Ownership of Material)	Contractor shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Contractor or developed during the course of the provision of the Services provided such generic documents or templates do not contain

	any DSHS Confidential Information or Data. Rights and ownership by Contractor of original technical designs, methods, ideas, concepts, know-how, and techniques shall not extend to or include all or any part of DSHS's DSHS Confidential Information or Data. To the extent that Contractor may include in the materials any pre-existing Contractor proprietary information or other protected Contractor materials, Contractor shall provide to DSHS […]
Additional Terms	**Limitation of Liability.** In the event of any claim arising from services provided by Contractor at any time, the total liability of Contractor, its officers, directors, agents and employees to DSHS shall not exceed five million dollars ($5,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract, or otherwise. In no event shall Contractor be liable for lost profits of DSHS or any other type of incidental or consequential damages. The foregoing limitation shall not apply in the event of the gross negligence, fraud or willful misconduct of the Contractor. **Third Party Distribution.** Contractor's work is prepared solely for the use and benefit of DSHS and the State of Washington in accordance with its statutory and regulatory requirements. Contractor recognizes that materials it delivers to DSHS shall be public records that may be subject to disclosure to third parties, as determined by DSHS in accordance with applicable laws. However, Contractor does not intend to benefit and assumes no duty or liability to any third parties who receive Contractor's work and may include disclaimer language on its work product so stating. DSHS agrees not to remove any such disclaimer language from Contractor's work.

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

CATHY BETTS
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Office of the Director
P. O. Box 339
Honolulu, Hawaii 96809-0339

DR 22.060

December 30, 2022

The Honorable Ronald D. Kouchi, President
and Members of the Senate
Thirty-Second State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirty-Second State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

Enclosed is the following report submitted in response to Senate Resolution 4 Senate Draft 1 Requesting The Department Of Human Services To Study The Feasibility Of Increasing The Medicaid Reimbursement Rates For Community Care Foster Family Homes, Expanded Adult Residential Care Homes, And Other Types Of Home And Community Based Service Care Providers And Services.

In accordance with section 93-16, HRS, the report is available to review electronically at the Department's website, at https://humanservices.hawaii.gov/reports/legislative-reports/.

Sincerely,

Cathy Betts
Director

Enclosure
c: Governor's Office
Lieutenant Governor's Office
Department of Budget & Finance
Legislative Auditor
Legislative Reference Bureau Library (1 hard copy)
Hawaii State Public Library, System State Publications Distribution Center (2 hard copies, 1 electronic copy)
Hamilton Library, Serials Department, University of Hawaii (1 hard copy)

REPORT TO THE THIRTY-SECOND HAWAII STATE LEGISLATURE 2023

Submitted In Response To Senate Resolution 4 Senate Draft 1 Requesting The Department Of Human Services To Study The Feasibility Of Increasing The Medicaid Reimbursement Rates For Community Care Foster Family Homes, Expanded Adult Residential Care Homes, And Other Types Of Home And Community Based Service Care Providers And Services

DEPARTMENT OF HUMAN SERVICES
MED-QUEST Division
December 2022

Senate Resolution 4 Senate Draft 1 requested the Department of Human Services (DHS) to

(1) Review the existing payment model for Medicaid reimbursement for patients who require nursing home-level of care in the community;
(2) Study the feasibility of increasing the Medicaid reimbursement rates for CCFFH, E—ARCH, and other types of Home and Community Based Service (HCBS) care providers and services; and
(3) Determine the overall effect of increasing the Medicaid reimbursement rates for CCFFH, E—ARCH, and other types of HCBS care providers and services.

Interest in strengthening long-term care services and supports is of broad interest nationally and in Hawaii. Recently, a Council of State Governments Task Force on Effective & Sustainable Long-Term Care with Hawaii representation included a work group focused on sustainable funding. DHS Med-QUEST Division (MQD) co-led the group, which authored a short briefing paper with national, local, and state recommendations. One of the recommendations included a rate study for HCBS services (see attached).

MQD completed a study of Home and Community Based rates paid for Community Care Foster Family Homes (CCFFHs), Expanded – Adult Residential Care Homes (E-ARCH), and other HCBS services. DHS MQD contracted Milliman, an actuarial firm, for a wide range of services and to do the study. The study commenced in July 2022, and MQD issued the final report on December 30, 2022 (see attached).

The study included Community Residential providers: CCFFHs and E-ARCHs, In-Home Services, and Case Management Services. The attached report contains complete descriptions of the various providers and services.

A key part of this rate study included stakeholder outreach and engagement with HCBS providers and their associations, collecting provider cost and wage survey data, and getting provider feedback on draft rate calculations. Not surprisingly, the provider surveys showed significant wage pressure given the current labor market. The rate study methodology used wage and salary data for direct care staff and supervisors, employee-related expenses, transportation and administration, program support, overhead, and Bureau of Labor and Industry Wage Indices to pay for employee benefits such as health insurance.

The rate study provides three scenarios (low, medium, and high) based on different wage or caseload/staffing assumptions. A low scenario includes the lowest wage or highest caseload assumptions to calculate the lowest rates; a medium scenario includes middle wage or caseload assumptions. A high scenario includes the highest wages or lowest caseload assumptions to calculate the highest rates (e.g., adjusting wages would create a low scenario with wage assumptions set at the 25th percentile, the medium scenario with wage assumptions set at the 50th percentile, and a high scenario with wage assumptions set at the 75th percentile). Modeled comparison rates under all rate scenarios exceed the 2021 baseline MQD rates.

The tables below provide the rate scenarios for the low, medium, and high options for CCFFHs and E-ARCHs. Although the Level 1 Low Rate Scenario is relatively modest, around 5%, all other scenarios show significant increases, particularly for the more complex, high acuity Level 2 residents.

E-ARCH Type I / CCFFH Cost-Share Residential Rate Scenarios

MODELED COMPARISON PER DIEM RATE SCENARIOS							
COST-SHARE RESIDENTIAL RATE COHORT	**CURRENT RATES (2022)**	**LOW**	**EST. % CHANGE LOW**	**MEDIUM**	**EST. % CHANGE MEDIUM**	**HIGH**	**EST. % CHANGE HIGH**
Level 1– Oahu	$56.50	$59.41	5.2%	$71.95	27.3%	$73.80	30.6%
Level 2– Oahu	$72.58	$95.65	31.8%	$116.24	60.2%	$119.39	64.5%
Level 1 – Neighbor Island	$61.50	$64.41	4.7%	$76.95	25.1%	$78.80	28.1%
Level 2 – Neighbor Island	$72.58	$100.65	38.7%	$121.24	67.0%	$124.39	71.4%

The estimated spend and the general/federal fund estimates show that for CCFFHs/E-ARCHs that an increase in spending of $13.5M ($7.91M A funds), $27.9M ($16.34M A funds) and $30.1M ($17.63M A funds) for the low, medium, and high rate scenarios, respectively.

The full HCBS Rate study report also includes the low, medium, and high rate scenarios for various In-home and case management services. In-home services reflected the most significant differential from current rates to the rate study scenarios, while case management services had the least. The estimated payment increases range from $23.8M ($13.9M A fund) to $40.4M ($23.7M A funds) for In-home services to $500k ($290k) to $2.3M ($1.35M A funds) for case management services.

The cost to increase all the HCBS Rate study services would range from $38M ($22M A funds) to $73M ($43M A funds). Although Med-QUEST has already incorporated a rate increase of 5-8% (about $7.55M) for these HCBS providers in their current capitation payments for QUEST Integration health plans, the estimated spend needed does not incorporate those increases. The increases are not incorporated because the rate increases use the American Rescue Plan Act Home and Community Based investment dollars, which are time-limited. Therefore, to sustain the increases over time, the Legislature would need to appropriate the total General Fund/Federal Fund amounts.

Estimated Modeled Comparison Rate Impact (in millions)

Scenarios	Low		Medium		High	
SERVICE CATEGORY	Estimated Payment Change	Estimated General Fund	Estimated Payment Change	Estimated General Fund	Estimated Payment Change	Estimated General Fund
Residential services	$13.50	$7.91	$27.90	$16.34	$30.10	$17.63
In-home services	$23.80	$13.94	$34.70	$20.32	$40.40	$23.66
Case management services	$0.50	$0.29	$1.30	$0.76	$2.30	$1.35
Total Rate Study Services	**$37.90**	**$22.19**	**$64.00**	**$37.48**	**$72.90**	**$42.69**

Long-Term Care (LTC) Reimbursement Working Group Recommendations

Long-term care comprises a broad continuum of long-term services and supports (LTSS) that includes institutional care provided in settings such as nursing facilities, alternative residential settings, and home- or community-based supports. This lattermost category is called home- and community-based services (HCBS) and includes services such as adult day health, adult day care, and personal attendant care.

The primary task of the LTC Reimbursement Working Group was to make recommendations to the federal and Hawaii state government on ways to enhance, improve, and streamline reimbursement for long-term care that would increase the access to and quality of those services. The group met formally on September 23, 2022, and informally at other times to review and finalize the following recommendations that cover the full continuum of LTSS.

Federal Recommendations

Prevent Dramatic Cuts to Medicare Rates for Post-Acute Care Providers

Medicare is an important payer for nursing facilities and home health agencies. However, in its 2023 proposed rules for Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs), CMS planned to make dramatic cuts to Medicare reimbursements for both settings of care. In its proposals from earlier this year, CMS recommended slashing $320 million and $810 million, respectively, to nursing homes and home health agencies.

Large reductions in payment at a time when many providers are experiencing both increased costs for providing care and decreased revenues due to the pandemic threaten patient access by harming the financial sustainability of providers. Although CMS reversed course in its final rule for SNFs and instead increased payments by $904 million, the final rule for HHAs has not yet been announced and has created uncertainty for the industry.

Ensuring that reimbursement covers the cost of care as well as incentivizes quality and value is essential to protecting patient access to services, especially in rural or underserved areas like the neighbor islands where access to care is already limited. Any changes to Medicare policies and reimbursements should be carefully implemented to avoid large, one-time cuts to providers and ensure that facilities are given enough lead time to adapt to program changes. In fact, Medicare should be considering how to better support the healthcare industry and patients by appropriately reimbursing providers and ensuring that payments are keeping up with the costs of inflation.

Adopt Federal Legislative Proposals to Improve the Long-Term Care Industry

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) supports a portfolio of federal legislative proposals known as the *Care for Our Seniors Act*. These changes would incentivize better patient care quality, revitalize the long-term care workforce, enhance industry oversight, and modernize the resident experience by making needed regulatory reforms, reinvesting in elder care, and redesigning programs that reward providers for delivering high-quality care.

Although components of the *Care for Our Seniors Act* have been introduced at various times since they were first recommended, none have been passed into law. Adopting these proposals – particularly

around workforce and staffing needs, which are currently the most acute issues for long-term care providers – would go a long way to ensuring that the nation's long-term care system remains robust enough to meet the needs of an aging population while also reducing the expense of providing and accessing care.

In addition to its many challenges, the pandemic has also created many opportunities. Across the country, thousands of people stepped up to serve as temporary nurse aides during the pandemic, introducing many into the healthcare field and the rewarding, meaningful work that it offers. However, with the expiration of certain pandemic flexibilities, these workers are not able to apply this on-the-job experience to parts of their licensure requirements. The *Building America's Health Care Workforce Act* was introduced in the House to create a clearer pathway to fulfilling careers in healthcare and would go a long way to ameliorating some of the workforce challenges facing SNFs.

Expand the Involvement of the Federal Government in Covering Long-Term Care Services and Supports

The demand for long-term care will only increase as the nation's population ages. However, the accessibility of and options to pay for this category of services is not uniform. The state where a person resides, their own financial circumstances, and the variability of a person's needs as they age affect their eligibility, coverage, and access to LTSS. Consequently, many people must piece these disparate pieces together themselves, often leaving at least some of their needs unmet.

Further, Medicaid is the largest payer of LTSS in the country. However, Medicaid eligibility is tied to income and the individual's level of care needs. Although Medicare provides health coverage for older adults, it plays a relatively limited role in funding LTSS. Congress should consider how the federal government can expand access to LTSS to ensure that access to LTSS is not primarily dependent on meeting Medicaid income eligibility criteria.

In 2011, with the passage of the Affordable Care Act, the federal government recognized the need for reform when the Community Living Assistance Services and Supports (CLASS) Act was created to provide coverage for a variety of long-term services and supports that a person might need such as home care, adult day care, or stays in a nursing home. However, the CLASS Act was repealed in 2013. Unfortunately, in the time since, nothing has emerged from the federal government as an alternative despite the growing need. The federal government should examine ways to create a sustainable, uniform way of paying for long-term care services that also address the institutional bias towards nursing facilities by investing in HCBS. This could include expanding the role of Medicare in providing LTSS (especially for dually eligible beneficiaries) or by creating a new program such as a full-cost buy-in option for Medicaid HCBS for those who do not otherwise meet Medicaid financial eligibility criteria.

The federal government should also consider, through Medicare or another financing program, covering a wider range of home- and community-based services. Increasingly, seniors want to age in place and people with disabilities want opportunities to live, work, and play in their communities. More investment is needed to make that a reality. Reimbursement for those critical home and personal care services will be needed along with a concentrated effort to build out the necessary workforce to provide those services. Also, policy changes in Medicaid to move HCBS from waivered services to be, at a minimum, optional Medicaid benefits would also support the provision of LTSS across the continuum.

State Recommendations

Conduct a Medicaid Rate Survey

The pandemic dramatically impacted healthcare and long-term care delivery systems. Many of these changes – particularly as they relate to patient preferences, facility staffing practices, and technology utilization – will persist long after the pandemic abates. Accordingly, now is an opportune time to revisit prior thinking about long-term care reimbursement and investigate ways that it can be reimagined to promote patient care quality, support livable wages for staff, and maximize efficiency.

Med-QUEST should undertake rate studies to better understand how the pandemic has shaped long-term care providers. These studies should consider how patient preferences have shifted away from institutional settings and to home- and community-based ones; how patient needs evolve with the aging population; the growing complexity of patient care; and what can be done to align reimbursement with long-term trends in Hawaii. Specific attention is also necessary on programs that reward high-quality care; incentivize accepting and caring for Medicaid beneficiaries (especially those with complex needs); pay wages necessary for the recruitment and retention of staff across the LTC continuum; and consider the need to update the aging physical infrastructure of many of the state's facilities.

It is also important to focus on HCBS providers who serve groups with high utilization of services and who have gone the longest without a rate update such as case management agencies, community care foster family homes, and adult day health and day care centers. CMS is also changing payment methods for nursing facilities. State Medicaid agencies will need to adopt new reimbursement methodologies that align with the new federal payment system. These all create opportunities to revise how providers of long-term care are reimbursed to better meet current and future needs.

Finally, there are no current assisted living facility (ALF) providers in the state who accept Medicaid in part because of the low reimbursement rate and different market forces for assisted living settings. Med-QUEST and the Healthcare Association of Hawaii are currently researching changes to Medicaid payment rates to potentially incentivize ALF providers to take Medicaid patients and determine how best to include ALFs in any long-term strategic plan.

Examine Ways to Improve Access for Patients with Complex Medical Needs

Caring for patients with complex medical needs has always been challenging, especially during the pandemic. Of particular concern, as noted earlier, is the rising need for behavioral health treatment as an additional patient need – especially among persons who are aged or living with a disability. Part of ensuring that patients with complex medical needs receive the care that they need is ensuring that provider reimbursement better reflects the more resource-intensive nature of offering this category of care and aligning incentives for providing this care.

To address the issue of complex care, Med-QUEST is working with providers and other community stakeholders to research innovative payment methodologies that incentivize providing services for these individuals and rewarding the value and quality of the care that is provided. Also being discussed are increasing payments for services that require more resource-intensive care. This includes modifying subacute care rates that will pay long-term care providers like nursing facilities at higher rates if they take on patients with more complex needs such as patients who have behavioral health needs, who need specialized bariatric care, or who are currently unhoused. Similarly, enhanced provider education

and training to be able to meet the unique needs of these beneficiary groups is necessary to ensure that patients are cared for appropriately and that their challenges are being addressed. Med-QUEST should continue its dialogue with payers and providers on the ways to best ensure that future rates target and treat individuals with complex medical needs.

Reauthorize and Maximize the Nursing Facility Sustainability Program

First established in 2012, the Nursing Facility Sustainability Program is a program that assesses fees on SNFs to draw down matching federal funds that are then returned to SNFs to help make up for the difference in reimbursement between Medicare and Medicaid. This program utilizes no state funds and – in the decade since its inception – has been critical to protecting Medicaid patients' access to skilled nursing services and maintaining the sustainability of the state's healthcare system.

In the upcoming legislative session, the Nursing Facility Sustainability Program will need to be reauthorized. As part of its deliberations, the Hawaii State Legislature should consider permanently authorizing the program and making other changes that would maximize the amount of federal funds that the program can draw down.

Explore Ways to Strengthen Hawaii's Informal Caregiving System

Hawaii has a strong tradition of informal caregiving through family, friends, and neighbors. This practice has been recognized and augmented through a variety of programs such as the Community Living Program and Kupuna Caregivers Program. The former enables recipients to self-direct their own care by hiring care workers – most commonly friends or family members – to provide the lower-level care that they need to avoid institutionalization. The Kupuna Caregivers Program enables unpaid primary caregivers to continue their employment by offering a variety of long-term supports and services to seniors while their caregivers are working. These modest investments ensure that frail older adults are well cared for in their communities, saving the healthcare system in avoidable downstream costs. Consequently, policymakers should explore opportunities to build upon the network of caregiving that already exists in many communities, strengthen the existing programs, and educate the public about the availability of these as alternatives to more costly forms of care delivery.

MILLIMAN REPORT

Home and Community-Based Services (HCBS) Rate Study Report

Commissioned by the State of Hawai`i Med-QUEST Division

December 30, 2022

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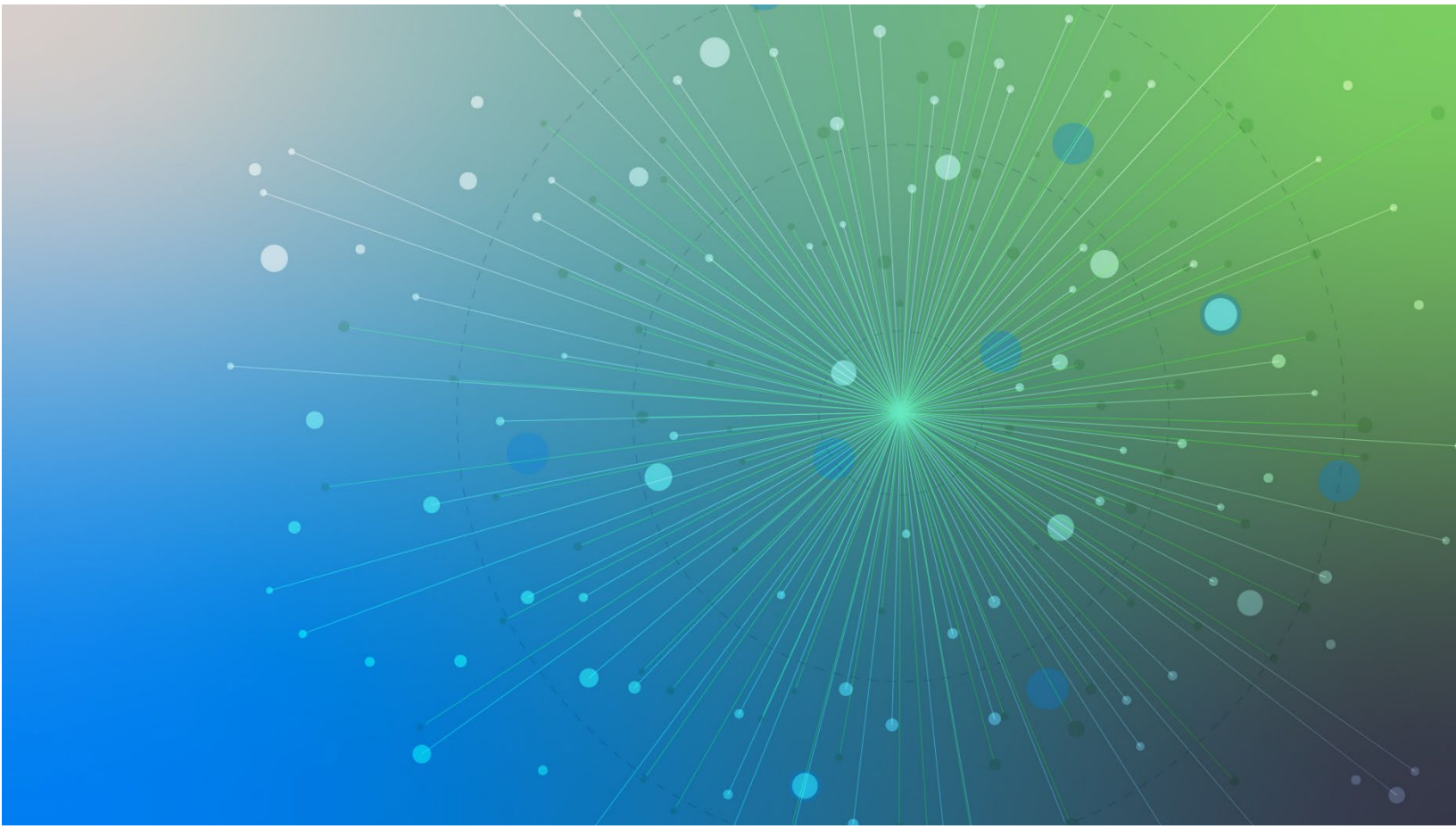

Milliman

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Executive Summary

OVERVIEW

The Hawai`i Department of Human Services – Med-QUEST Division (MQD) engaged Milliman Inc. (Milliman) to develop a Medicaid Home and Community-Based Services (HCBS) rate study. This rate study includes the development of benchmark "comparison rates" for select services that providers and QUEST Integration (QI) Medicaid Managed Care Organizations (MCOs) could consider when negotiating contracts, and that the State and other stakeholders can use when evaluating changes to overall funding. This rate study also establishes payment methodologies under an Independent Rate Model (IRM) that can be leveraged across other HCBS rates going forward. *Note that before implementing the comparison rates developed in this rate study, there are a number of implementation steps that must be considered as described in this report.*

MQD commissioned this HCBS rate study in response to the following initiatives:

- In 2022, the State of Hawai`i legislature passed Senate Resolution #4, which requests "the Department of Human Services to study the feasibility of increases the Medicaid reimbursement rates for Community Care foster family homes, expanded adult residential care homes, and other home and community care provider services."[1]
- MQD's HCBS spending plan under the American Rescue Plan Act of 2021 (ARPA), which specifies the "initiative will include a rate study to identify baseline rates and establish competitive rate methodologies."[2]

This initial phase of the HCBS rate study focuses on the following key services selected by MQD that were included in MQD's ARPA spending plan and other highly utilized QI HCBS services:

- Residential services:
  - Community Care Foster Family Home (CCFFH)
  - Expanded Adult Residential Care Home (E-ARCH Type 1)
- In-home services:
  - Homemaker/Companion/Chore (PA1)
  - Personal Care/Personal Assistance/Attendant Care (PA2)
  - Private Duty Nursing Registered Nurse (RN) and Licensed Practical Nurse (LPN)
- Case management services:
  - Community Care Management Agency (CCMA)

Self-directed personal assistance rates have already been updated independent of this rate study. For the other QI HCBS services not listed above, MQD proposes to develop comparison rates in a future HCBS rate study phase that leverages the rate methodologies developed in this initial rate study.

As a key part of this rate study, we have conducted stakeholder outreach and engagement with HCBS providers and their associations, collected provider cost and wage survey data, and presented draft rate calculations for provider feedback. The feedback from discussions with HCBS provider stakeholders included the following main themes:

- HCBS providers face significant wage pressures for registered nurses (RNs) and certified nursing assistants (CNAs) and are competing with facilities and private pay services for the same labor force
- In-home care agencies face significant wage pressures from hotels and the tourism industry for personal assistance service staff
- Residential provider substitute caregiver compensation varies significantly, with some substitute caregivers that are paid and some unpaid (with some providers relying upon friends and family)
- Case management provider reimbursement levels are not sufficient for all providers to be able to employ RNs, and most providers primarily rely upon contracted RNs

[1] https://www.capitol.hawaii.gov/sessions/session2022/bills/SR4_SD1_.PDF

[2] https://www.medicaid.gov/sites/default/files/2021-10/hi-spending-plan-for-implementation.pdf

- Reimbursement levels generally do not enable providers to offer benefits, including health insurance, to employees
- Providers strongly support formalized enhanced "level 3" rates for individuals with high behavioral needs and some providers have already negotiated enhanced "level 3" rates with MCOs

To incorporate provider feedback and to support the rate development process, Milliman leveraged the IRM framework. The assumptions within the IRM were informed by stakeholder feedback, independent research, provider survey responses, and policy decisions by MQD. The modeled comparison rates under the IRM include the following key components as outlined in Figure 1 (see the *Methodology and Data Relied Upon* section of this report for more details):

Figure 1: Independent Rate Model Components

IRM COMPONENT	DESCRIPTION
Direct Care Staff and Supervisor Salaries and Wages	Includes labor-related costs for direct care staff and supervisors, for both employee wages and salaries and contractor rates
Employee Related Expenses (ERE)	Includes payroll-related taxes and fees and employee benefits
Transportation	Includes vehicle operating expenses
Administration, Program Support, Overhead	Includes program operating expenses, including management, accounting, legal, information technology, etc., excluding room and board (per CMS requirements and consistent with MQD's approved 1115 demonstration)[3]

The IRM components listed above provide a consistent framework across services, while still allowing for customization for each service to determine the appropriate reimbursement level and service delivery incentives. The labor cost assumptions in the IRM provide clear and transparent expectations for the assumed direct care professional wages and benefits levels for providers to follow. The IRM also provides MQD with a mechanism for future rate updates and for developing rates for new services and/or service definitions (e.g., in the event MQD establishes a new level 3 care definition).

MODELED COMPARISON RATES AND ESTIMATED IMPACT

To support budget estimates and potential new state general fund requirements for the State's consideration, MQD requested a range of modeled comparison rate scenarios. Per MQD's direction we have modeled three rate scenarios for each service ("Low", "Medium", and "High") under different direct care staff wage and caseload assumptions. A low scenario includes the lowest wage or highest caseload assumptions to calculate the lowest rates, a medium scenario includes middle wage or caseload assumptions, and a high scenario includes the highest wages or lowest caseload assumptions to calculate the highest rates (e.g., adjusting wages would create a low scenario with wage assumptions set at the 25th percentile, medium scenario with wage assumptions set at the 50th percentile, and a high scenario with wage assumptions set at the 75th percentile). Modeled comparison rates under all rate scenarios exceed rates published in MQD's QI memos and average calendar year (CY) 2021 service rates paid by MCOs to providers, and therefore are anticipated to result in expenditure increases if utilized by MCOs.

Figure 2 below provides a summary of modeled comparison rate scenarios for CCFFH and E-ARCH Type 1 providers for cost-share residents. Residential service rates continue to include the current $5 per day rate increase between Oahu and the Neighbor Islands. For detailed rate calculations, see **Appendix A** of this report.

[3] https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/Hawaii_QUEST_Integration_1115_Demonstration_Extension_Approval_Package.pdf

Figure 2: E-ARCH Type I / CCFFH Cost-Share Residential Rate Scenarios

COST-SHARE RESIDENTIAL RATE COHORT	CURRENT MQD QI MEMO PER DIEM RATES (2022)	MODELED COMPARISON PER DIEM RATE SCENARIOS					
		LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Level 1–- Oahu	$56.50	$59.41	5.2%	$71.95	27.3%	$73.80	30.6%
Level 2–- Oahu	$72.58	$95.65	31.8%	$116.24	60.2%	$119.39	64.5%
Level 1 – Neighbor Island	$61.50	$64.41	4.7%	$76.95	25.1%	$78.80	28.1%
Level 2 – Neighbor Island	$72.58	$100.65	38.7%	$121.24	67.0%	$124.39	71.4%

Figure 3 below provides a summary of modeled comparison rates scenarios for in-home services. For detailed rate calculations, see **Appendix A** of this report.

Figure 3: In-Home Services Rate Scenarios

IN-HOME SERVICE	AVERAGE PAYMENT PER 15-MINUTE UNIT (2021)	MODELED COMPARISON RATE SCENARIOS – 15 MINUTE UNIT					
		LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Personal Assistance – Level 1	$5.56	$8.75	57.4%	$10.26	84.5%	$11.04	98.6%
Personal Assistance/Attendant Care – Level 2	$6.70	$11.42	70.4%	$13.39	99.9%	$14.10	110.4%
Private Duty Nursing/Attendant Care – LPN	$11.00	$14.08	28.0%	$14.43	31.2%	$15.77	43.4%
Private Duty Nursing/Attendant Care – RN	$14.77	$22.07	49.4%	$26.83	81.7%	$31.16	111.0%

Figure 4 below provides a summary of modeled comparison rates scenarios for CCMA rate scenarios. For detailed rate calculations, see **Appendix A** of this report.

Figure 4: CCMA Services Rate Scenarios

SERVICE DESCRIPTION	AVERAGE PAYMENT PER DIEM (2021)	MODELED COMPARISON PER DIEM RATE SCENARIOS					
		LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Case management	$13.15	$ 13.88	5.6%	$ 15.06	14.5%	$ 16.48	25.3%

Based on the above modeled rates and CY 2021 service utilization, we estimate total modeled payments will be approximately $37.9 million to $72.9 million above CY 2021 expenditure levels, depending on the selected rate scenario. Estimated payment impacts do not consider rate increases that have been provided by MCOs since CY 2021, which MQD expects to make as a result of capitation rate increases for HCBS and effective January 1, 2023. These January 2023 capitation rate increases were based on an 8.6% increase above 2021 expenditures, projected to be approximately $4.25 million. When considering state general fund requirements for potential HCBS rate increases, MQD should consider these HCBS reimbursement changes since 2021.

Actual QI HCBS payments made by MCOs to providers will differ from the simulated payments in this modeling. Reasons for differences include but are not limited to future changes in enrollment, utilization, service mix, negotiated rates between MCOs and providers, and other factors.

Figure 5 below provides a summary of modeled payment increases under the modeled rate scenarios, by service category:

Figure 5: Estimated Modeled Comparison Rate Impact

		"LOW" SCENARIO ($ MILLIONS)		"MEDIUM" SCENARIO ($ MILLIONS)		"HIGH" SCENARIO ($ MILLIONS)	
SERVICE CATEGORY	CY 2021 PAYMENTS ($ MILLIONS)	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE
Residential services	$39.5	$53.0	$13.5	$67.4	$27.9	$69.6	$30.1
In-home services	$38.4	$62.2	$23.8	$73.1	$34.7	$78.8	$40.4
Case management services	$9.3	$9.8	$0.5	$10.6	$1.3	$11.6	$2.3
Total Rate Study Services	**$87.1**	**$125.0**	**$37.9**	**$151.1**	**$64.0**	**$160.0**	**$72.9**

Note that the modeled payment impact for residential service as shown above is based on MQD's published QI memo rates and does not reflect negotiated rates between MCOs and providers (such as negotiated Level 3 rates) or the impact of cost-share population spend-down. Estimated payment impacts for in-home services and case management services reflect actual MCO expenditures.

Estimated payment increases under the modeled rate scenarios reflect reimbursement levels that enable competitive wages for direct care staff, health benefits for employees, and reimbursement for all service-related time (including both direct and indirect time). To replicate current reimbursement levels under the IRM, we would need to adjust the rate assumptions to reflect lower wages, limited health employee benefits, and potentially uncompensated direct service time, which is consistent with provider feedback and survey data on current HCBS provider business practices.

IMPLEMENTATION CONSIDERATIONS

If the State decides to move forward with the comparison rates developed in this rate study, it will need to consider the following key implementation steps:

- Obtain additional state general funds for rate increases
- Discuss new rate methodologies and modeled rates with Medicaid MCOs
- Update managed care capitation rates and include in a new rate certification for CMS approval
- Distribute QI memos with MQD's selected comparison rates for each service
- Discuss with HCBS providers the assumptions on direct care staff wages, employee benefits, and staffing ratios/caseloads built into the modeled comparison rates

Introduction and Background

The State of Hawai`i Med-QUEST Division (MQD) engaged Milliman Inc. (Milliman) to develop a Medicaid Home and Community-Based Services (HCBS) rate study. This rate study includes the development of benchmark "comparison rates" for select services that providers and QUEST Integration (QI) Medicaid Managed Care Organizations (MCOs) can use when negotiating contracts, and that the State and other stakeholders can use when evaluating changes to overall funding. This rate study also establishes payment methodologies under an Independent Rate Model (IRM) that can be leveraged across other HCBS rates going forward, as described in detail in the *Methodology and Data Relied Upon* section of this report. *Note that before implementing the comparison rates developed in this rate study, there are a number of implementation steps that must be considered as described in this report.*

MQD commissioned this HCBS rate study in response to the following initiatives:

- The State of Hawai`i legislature in 2022 passed Senate Resolution #4, which requests "the Department of Human Services to study the feasibility of increases the Medicaid reimbursement rates for Community Care foster family homes, expanded adult residential are homes, and other of home and community care provider and services."[4]
- MQD's HCBS spending plan under the American Rescue Plan Act of 2021 (ARPA), which specifies the "initiative will include a rate study to identify baseline rates and establish competitive rate methodologies", and involves the following HCBS Medicaid funding increases: [5]
  - *Reimbursing Self-Directed Workers at a Competitive Wage:* Increasing funding for self-direction will compete more effectively in the marketplace (particularly with tourism industry)
  - *Reimbursing Community Case Management Agencies (CCMAs) at a Competitive Wage:* Residential CCMA rate has remained the same over the past decade, while the acuity and complexity of the members being served have increased (particularly related to behavioral health)
  - *Reimbursing Residential Alternatives (Adult Foster Homes/Expanded Care Homes/Assisted Living) at a Competitive Wage:* Residential rates need to be competitive to entice caregivers to accept complex behavior/medical members, to attract new caregivers, to retain existing caregivers, or to slow the retirement of aging caregivers
  - *Building Capacity in Residential Alternatives to Serve Challenging Members:* Hawai`i needs to build provider capacity and willingness to accept the growing number of members with complex behavioral, and medical needs into HCBS residential settings
  - *Building Case Management Capacity Related to Challenging Members:* Case management agencies that visit and care for members with complex behavioral and physical need added capacity to handle complex members[6]

Per MQD's Section 1115 Waiver Demonstration, "MQD provides HCBS services via the Demonstration to two populations: (1) individuals who meet an institutional level of care requirement and (2) individuals who are assessed to be "at risk" of deteriorating to the institutional level of care."[7] This initial HCBS rate study focused on the following QI HCBS services selected by MQD that were included in the MQD ARPA spending plan and other highly utilized services:

- Residential Services:
  - Community Care Foster Family Home (CCFFH)
  - Expanded Adult Residential Care Home (E-ARCH Type 1)

[4] https://www.capitol.hawaii.gov/sessions/session2022/bills/SR4_SD1_.PDF

[5] https://www.medicaid.gov/sites/default/files/2021-10/hi-spending-plan-for-implementation.pdf

[6] https://www.medicaid.gov/sites/default/files/2021-10/hi-spending-plan-for-implementation.pdf

[7] https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/HI_Medicaid_1115_Evaluation_Design_Final_Approved_10-15-2020.pdf

- In-home services:
  - Homemaker/Companion/Chore (PA1)
  - Personal Care/Personal Assistance/Attendant Care (PA2)
  - Private Duty Nursing Registered Nurse (RN) and Licensed Practical Nurse (LPN)
- Case management services:
  - Community Care Management Agency (CCMA)

Self-directed personal assistance rates have already been updated independent of this rate study. For the other QI HCBS services not listed above, MQD proposes to develop comparison rates in a future HCBS rate study phase that leverages the rate methodologies developed in this initial rate study.

To support budget estimates and potential new state general fund requirements for the State's consideration, MQD requested a range of modeled comparison rate scenarios under the IRM approach. Per MQD's direction, we have modeled three rate scenarios for each service ("Low", "Medium", and "High") under different direct care staff wage and caseload assumptions. See the *Methodology and Data Relied Upon* section of this report for more details on the IRM development and payment impact modeling process.

The modeled comparison rates from this rate study do not constitute a requirement or commitment that MCOs or other payors adjust current payment arrangements to match these benchmarks, but rather they are informational for potential adoption by providers, MCOs, and other stakeholders during the rate negotiation process. Of particular note:

- MQD is not currently considering the adoption of comparison rates developed in this rate study as an MQD fee-for-service fee schedule or a § 438.6(c) state directed payment under managed care.
- Expected funding increases resulting from the modeled comparison rates in this rate study would not be incorporated into the managed care capitation rates until additional state general funds could be identified.
- The current capitation rate development process considers, among other data points, provider utilization and provider payments reported by MCOs as observed in the encounter data. To the extent that MCOs and providers negotiate their contracted rates through reliance on the comparison rates, capitation rates for future periods will include consideration of such changes through the annual rebasing of capitation rate development and as such changes emerge.
- MQD does not plan to reprice individual claims using the comparison rates when determining capitation rates to be paid to the MCOs.

Results

The results of this HCBS rate study are summarized below. ***Note that before implementing the comparison rates developed in this rate study, there are a number of implementation steps that must be considered as described in this report. Actual QI HCBS payments made by MCOs to providers will differ from the simulated payments in this modeling. Reasons for differences include but are not limited to future changes in enrollment, utilization, service mix, negotiated rates between MCOs and providers, and other factors.***

STAKEHOLDER FEEDBACK

As a key part of the HCBS rate study, we have conducted stakeholder outreach and engagement with HCBS providers and their associations, collected provider cost and wage survey data, and presented draft rate calculations for provider feedback. In addition to provider meetings, MQD created an HCBS project website[8] to post project related materials and both MQD and Millman had a specific email inbox to collect stakeholder feedback. The goal of the stakeholder engagement process was to establish an appropriate balance between building consensus among key stakeholders and achieving MQD financing and policy goals. The stakeholder engagement conducted for this rate study is summarized in Figure 6 below.

Figure 6: Rate Study Stakeholder Engagement

STAKEHOLDER ENGAGEMENT/MEETINGS	DESCRIPTION
Regular MQD Status Meetings	Milliman participated in scheduled meetings with MQD representatives. MQD and Milliman met bi-weekly at the onset of the project and met weekly over the last several months of the project. During these meetings, we discussed: ▪ Stakeholder engagement preparation ▪ Research findings ▪ Preliminary analyses, including draft comparison rates, wage changes, and self-directed rates Provider feedback from the provider workgroup sessions
Public Kick-off Meeting	MQD invited HCBS providers and MCOs to attend a project kickoff meeting with MQD and Milliman representatives regarding the comparison rate development process and its scope. Stakeholders were encouraged to provide feedback during the meeting and at any time in the future via e-mail. Stakeholders interested in joining service specific provider workgroups were invited to contact MQD.
First and Second Stakeholder Meetings	MQD and Milliman representatives held stakeholder meetings with the above mentioned three provider workgroups: CCMAs, in-home providers, and residential facilities. The primary goals of the provider workgroup meetings were to discuss the costs related to service delivery, the service requirements, and to review preliminary comparison rate assumptions and rates specific to each service type and gather feedback.

[8] "HCBS Rate Study" tab on the MQD webpage https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html.

STAKEHOLDER ENGAGEMENT/MEETINGS	DESCRIPTION
First Stakeholder Meeting Themes	Major themes from the first **CCMA** stakeholder meeting, included: ▪ Most case managers are contracted registered nurses (RNs) ▪ Social workers are helpful for more complex cases for comprehensive care but cannot fulfill the ongoing nurse delegation requirement ▪ CCMAs face significant wage pressures for RNs and are competing with facilities for the same labor force ▪ Most of the on-call nurse delegation is performed by the owners of the CCMA Major themes from the first **in-home service provider** stakeholder meeting, included: ▪ Some in-home service providers deliver a mix of PA1, PA2, and private duty nursing, while others only do one ▪ The direct services professionals PA1 and homemaker workers typically do not have a bachelor's degree but require training ▪ Agencies face significant wage pressures from hotels for PA1 services and nursing facilities and private pay services for PA2 services. ▪ PA2 services require a nurse supervisor for each case; RNs are typically a mix of part time and full-time employees Major themes from the first **residential provider** stakeholder meeting, included: ▪ Caregivers are primarily Certified Nursing Assistants (CNAs) ▪ The proportion of primary caregiver direct care hours (and use of substitute caregivers) varies across providers and depends on if the owner has additional employment outside of the residence ▪ Substitute caregiver compensation varies with some substitute caregivers that are paid and some unpaid ▪ Strong support for enhanced rate for level "3" for high behavioral problems ▪ Transportation typically provided using primary caregiver's own vehicle; trips can range from 2-3 times per week
Second Stakeholder Meeting Themes	During the second stakeholder meeting IRM components and assumptions and draft comparison rates were shared with the stakeholders for feedback. Major themes from the second **CCMA** stakeholder meeting, included: ▪ Discussion around the service definition and alignment with the rate ▪ Caseload sizes vary as it relates to the levels of need ▪ Future consideration for a rate that varies by level, particular for a new level 3 Major themes from the second **in-home service provider** stakeholder meeting, included: ▪ Draft rates are closer to private pay rates than current MCO rates and developmental disability services are comparable, but have more behavioral health service requirements ▪ Rates need to support shorter visits, which require higher pay due to variable scheduling ▪ Draft rates demonstrate "respect" for the workforce, which is challenging to recruit and retain due to workforce competition in hospitals and nursing facilities Major themes from the second **residential provider** stakeholder meeting, included: ▪ Proposed direct service hours are generally appropriate, but vary based upon the needs of an individual

MODELED COMPARISON RATES AND ESTIMATED IMPACT

To incorporate provider feedback and to support the rate development process, Milliman leveraged their IRM framework. The assumptions within the IRM were informed by stakeholder feedback, independent research, provider survey responses, and policy decisions by MQD (see the *Methodology and Data Relied Upon* section of this report for more details on the IRM key rate components). The IRM rate approach provides a consistent framework across services, while still allowing for customization for each service to determine the appropriate reimbursement level and service delivery incentives. The labor cost assumptions in the IRM provide clear and transparent expectations for the assumed direct care professional wages and benefits levels for providers to follow. The IRM also provides MQD with a mechanism for future rate updates and for developing rates for new services and/or service definitions (e.g., in the event MQD establishes a new level 3 care definition).

To support budget estimates and potential new state general fund requirements for the State's consideration, MQD requested a range of modeled comparison rate scenarios. Per MQD's direction we have modeled three rate scenarios for each service ("Low", "Medium", and "High") under different direct care staff wage and caseload assumptions. A low scenario includes the lowest wage or highest caseload assumptions to calculate the lowest rates, a medium scenario includes middle wage or caseload assumptions, and a high scenario includes the highest wages or lowest caseload assumptions to calculate the highest rates (e.g., adjusting wages would create a low scenario with wage assumptions set at the 25th percentile, medium scenario with wage assumptions set at the 50th percentile, and a high scenario with wage assumptions set at the 75th percentile). Modeled comparison rates under all rate scenarios exceed rates published in MQD's QI memos and average service rates paid by MCOs to providers, and therefore are anticipated to result in expenditure increases if utilized by MCOs for payment.

Figure 7 below provides a summary of modeled comparison rate scenarios for CCFFH and E-ARCH Type 1 providers for cost-share residents. Residential service rates continue to include the current $5 per day rate increase between Oahu and the Neighbor Islands. For detailed rate calculations, see **Appendix A** of this report.

Figure 7: E-ARCH Type I / CCFFH Cost-Share Residential Rate Scenarios

		MODELED COMPARISON PER DIEM RATE SCENARIOS					
COST-SHARE RESIDENTIAL RATE COHORT	CURRENT MQD QI MEMO PER DIEM RATES (2022)	LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Level 1–- Oahu	$56.50	$59.41	5.2%	$71.95	27.3%	$73.80	30.6%
Level 2–- Oahu	$72.58	$95.65	31.8%	$116.24	60.2%	$119.39	64.5%
Level 1 – Neighbor Island	$61.50	$64.41	4.7%	$76.95	25.1%	$78.80	28.1%
Level 2 – Neighbor Island	$72.58	$100.65	38.7%	$121.24	67.0%	$124.39	71.4%

Figure 8 below provides a summary of modeled comparison rates scenarios for in-home services. For detailed rate calculations, see **Appendix A** of this report.

Figure 8: In-Home Services Rate Scenarios

		MODELED COMPARISON RATE SCENARIOS – 15 MINUTE UNIT					
IN-HOME SERVICE	AVERAGE PAYMENT PER 15-MINUTE UNIT (2021)	LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Personal Assistance – Level 1	$5.56	$8.75	57.4%	$10.26	84.5%	$11.04	98.6%
Personal Assistance/Attendant Care – Level 2	$6.70	$11.42	70.4%	$13.39	99.9%	$14.10	110.4%
Private Duty Nursing/Attendant Care – LPN	$11.00	$14.08	28.0%	$14.43	31.2%	$15.77	43.4%
Private Duty Nursing/Attendant Care – RN	$14.77	$22.07	49.4%	$26.83	81.7%	$31.16	111.0%

Figure 9 below provides a summary of modeled comparison rates scenarios for CCMA rate scenarios. For detailed rate calculations, see **Appendix A** of this report.

Figure 9: CCMA Services Rate Scenarios

		MODELED COMPARISON PER DIEM RATE SCENARIOS					
SERVICE DESCRIPTION	AVERAGE PAYMENT PER DIEM (2021)	LOW	EST. % CHANGE LOW	MEDIUM	EST. % CHANGE MEDIUM	HIGH	EST. % CHANGE HIGH
Case management	$13.15	$ 13.88	5.6%	$ 15.06	14.5%	$ 16.48	25.3%

Based on the above modeled rates and Calendar Year (CY) 2021 service utilization, we estimate total modeled payments (total computable, including the state share and non-federal share) will be approximately $37.9 million to $72.9 million above CY 2021 expenditure levels for all three service categories combined, depending on the selected rate scenario. Actual QI HCBS payments made by MCOs to providers will differ from the simulated payments in this modeling. Reasons for differences include but are not limited to future changes in enrollment, utilization, service mix, negotiated rates between MCOs and providers, and other factors.

These estimates are based on CY 2021 Medicaid MCO utilization. To establish 2021 baseline data, we multiplied the CY 2021 units against the average amount paid per unit for in-home and case management services, and for residential services we multiplied CY 2021 days by the CY 2021 residential QI memo rates. We compared the CY 2021 baseline data against the calculated rate scenarios to create three estimated payment impacts. Estimated payment impacts do not consider rate increases that have been provided by MCOs since CY 2021, which MQD expects to make as a result of capitation rate increases for HCBS and effective January 1, 2023. These January 2023 capitation rate increases were based on an 8.6% increase above 2021 expenditures, projected to be approximately $4.25 million. When considering state general fund requirements for potential HCBS rate increases, MQD should consider these HCBS reimbursement changes since 2021.

Figure 10 below provides a summary of modeled payment increases under modeled rate scenarios, by service category:

Figure 10: Estimated Modeled Comparison Rate Impact

		"LOW" SCENARIO ($ MILLIONS)		"MEDIUM" SCENARIO ($ MILLIONS)		"HIGH" SCENARIO ($ MILLIONS)	
SERVICE CATEGORY	CY 2021 PAYMENTS ($ MILLIONS)	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE	ESTIMATED PAYMENTS	ESTIMATED PAYMENT CHANGE
Residential services	$39.5	$53.0	$13.5	$67.4	$27.9	$69.6	$30.1
In-home services	$38.4	$62.2	$23.8	$73.1	$34.7	$78.8	$40.4
Case management services	$9.3	$9.8	$0.5	$10.6	$1.3	$11.6	$2.3
Total Rate Study Services	**$87.1**	**$125.0**	**$37.9**	**$151.1**	**$64.0**	**$160.0**	**$72.9**

Note that the modeled payment impact for residential service as shown above is based on MQD's published QI memo rates and does not reflect negotiated rates between MCOs and providers (and therefore does not reflect the impact of negotiated Level 3 rates). Estimated payment impacts for in-home services and case management services reflect actual CY 2021 MCO expenditures.

Estimated payment increases under the modeled rate scenarios reflect reimbursement levels that enable competitive wages for direct care staff, health benefits for employees, and reimbursement for all service-related time (including both direct and indirect time). To replicate current reimbursement levels under the IRM, we would need to adjust the rate assumptions to reflect lower wages, limited health employee benefits, and potentially uncompensated direct service time, which is consistent with provider feedback and survey data on current HCBS provider business practices.

IMPLEMENTATION CONSIDERATIONS

If the State decides to move forward with the comparison rates developed in this rate study, it will need to consider the following key implementation steps:

- Obtain additional state general funds for rate increases
- Discuss new rate methodologies and modeled rates with Medicaid MCOs
- Update managed care capitation rates and include in a new rate certification for CMS approval
- Distribute QI memos with MQD's selected comparison rates for each service
- Discuss with HCBS providers the assumptions on direct care staff wages, employee benefits, and staffing ratios/caseloads built into the modeled comparison rates

Methodology and Data Relied Upon

The comparison rate modeling approach relied upon for this rate study was the IRM, which approximates the average costs that a reasonably efficient HCBS provider would be expected to incur while delivering these services. As denoted by its description – ***independent*** rate model – this approach builds rates from the ground up, by determining the costs related to the individual components shown below and summing the component amounts to derive a comparison rate for each service.

The IRM approach can be distinguished from other provider payment methodologies in that it estimates what the costs for each service could be given the resources (salaries and other expenses) reasonably expected to be required, on average, while delivering the services. This approach relies on multiple independent data sources to develop rate model assumptions to construct the comparison rates. By contrast, many cost-based methods rely primarily on the actual reported historical costs incurred while delivering services, which can be affected by operating or service delivery decisions made by providers, and can be limited by current reimbursement level. These operating or service delivery decisions may be inconsistent with program service delivery standards or be caused by program funding limitations that do not necessarily consider the average resource requirements associated with providing these services or include incentives for direct care staff retention. Figure 9 provides an overview of the key components and elements of the IRM approach. The IRM approach constructs a rate for each service as the sum of the costs associated with each of the components shown in Figure 11.

Figure 11: INDEPENDENT RATE MODEL COMPONENTS

COMPONENT	ELEMENTS	SUB-ELEMENTS	CLARIFYING NOTES
Clinical Staff and Supervisor Salaries and Wages	Service-related Time	Direct Time	Corresponding time unit, or staffing requirement assumptions where not defined Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling sessions or for residential services).
		Indirect Time	Service-necessary planning, note taking and preparation time
		Transportation Time	Travel time related to providing service
		PTO/Training/ Conference Time	Paid vacation, holiday, sick, training, non-productive, and conference time; also considers additional training time attributable to employee turnover
		Supervisor Time	Accounted for using a span of control variable
	Wage Rates	Can Vary for Overtime	Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
Employee Related Expenses (ERE)	Payroll-related Taxes and Fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers Compensation	Applicable to all employees, and varies by wage level assumption
	Employee Benefits	Health, Dental, Vision, Life and Disability Insurance, and Retirement Benefits	Amounts may vary by provider group
Transportation	Vehicle Operating Expenses	Includes all Ownership and Maintenance-Related Expenses	Varies by service with costs estimated based on the IRS reimbursement rate.
Administration, Program Support, Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	Excludes room and board expenses.

Rate Model Components

This subsection provides a description of the key rate components listed in Figure 11, which are:

- Direct care staff and supervisor salary and wages
- Employee related expenses
- Administration, program support, overhead
- Transportation
- Residential hours

We provide a summary of the potential fiscal impact using CY 2021 utilization data. The calculated rates are listed in Appendix A.

Direct Care Staff and Supervisor Salary and Wages

The direct care staff salary and wage components are typically the largest component of rates, comprising the labor-related cost, or the product of the time and expected wage rates for the direct care staff who deliver each of the services. This component includes costs associated with the direct care staff expected to deliver the services and their immediate supervisors.

Direct Care Staff and Supervisor Time Assumptions

In the IRM approach, direct care staff time is categorized as direct time, indirect time, floating staff time, and supervisor time. Adjustments for paid time off (PTO), holidays, and training time are also incorporated. There are also other time assumptions that are services specific. All assumptions were reviewed with stakeholders for feedback. Figure 12 provides a description of each of these sub-elements and related adjustments.

Figure 12: SUMMARY OF SUB-ELEMENTS RELATED TO DIRECT CARE STAFF AND SUPERVISOR TIME

TIME

SUB-ELEMENT	DEFINITION	ASSUMPTIONS
Direct Care Staff Direct Time	▪ Amount of time incurred by direct staff that can be billed for services provided to individuals. ▪ For example, a service billed as a 15-minute unit assumes that the direct care staff direct time is approximately 15 minutes, an assumption that is consistent with service billing guidelines. Examples of the most common unit types, which vary by service, are a set number of minutes per service unit (e.g., 15-minute, 30-minute), per encounter, per day, or per month.	▪ In-home services are assumed to have 15-minutes of direct service time. ▪ For service units that are not defined by a time unit (e.g., per encounter or per diem) direct time assumptions were developed for each procedure code. ▪ Assumptions included in the IRM were reviewed with stakeholders.
Direct Care Staff Indirect Time	▪ Time that must be spent by non-supervisory direct care staff to provide the service, but is not spent "person facing", and does not result in a billable unit of service. ▪ Time incurred for necessary activities such as planning, summarizing notes, updating records, and other non-billable but appropriate time not otherwise included in direct care staff direct time.	▪ Indirect time assumptions are assumed at 2 minutes per 15 minutes of direct service time for in-home services. ▪ Assumptions included in the IRM were reviewed with stakeholders.
On-Call Staff Time	▪ Time that is allocated for "on-call" services that are outside of normal working hours.	▪ For CCMA services there is 0.1 full time equivalent (FTE) added to the IRM to account for on-call requirements. ▪ CCMA stakeholders provided feedback about the after-hour calls from hospitals and residential providers, which supported this rate assumption. ▪ Assumptions included in the IRM were reviewed with stakeholders.

TIME SUB-ELEMENT	DEFINITION	ASSUMPTIONS
PTO Adjustment Factor	▪ Accounts for additional time that must be covered over the course of a year by other staff, thereby representing additional direct care staff time per unit. ▪ Annual time related paid vacation, holiday, and sick time. ▪ Annual training and/or conference time expected to be incurred by direct care staff and supervisors. ▪ Increased for an estimate that considers the amount of one-time training/onboarding and the frequency of this type of training time that can be attributable to employee turnover.	▪ Varies by provider type. ▪ Appendix B provides the PTO and training assumptions by provider type. ▪ Assumptions included in the IRM were reviewed with stakeholders.
Supervisor Time	▪ For the services included in this analysis, staff providing services to individuals require supervision. ▪ Supervisors, commonly referred to as front line supervisors, are typically more experienced or higher credentialed provider types responsible for the direct oversight and supervision of those employees that are directly providing the services to individuals. ▪ Supervision of direct care staff does not result in a separate billable unit of service. ▪ Some providers may not have second-line supervisors while other organizations may operate a two-tiered supervision approach to support direct care staff directly providing services. ▪ Supervisor responsibilities may vary, but primarily are providing direct supervising, hiring, training and discipline of the direct care staff, whose primary responsibilities are providing services. Supervisor responsibilities may also include program planning and evaluation, advocacy, working with families, and working with community members. ▪ Supervisor time is determined through application of a “span of control” assumption, which is a measure of how many clinical staff a supervisor can supervise	▪ For in-home services, a supervisor span of control assumption of 1:10 was used, meaning that on average, every 10 hours of clinical staff time will require one hour of a supervisor’s time. ▪ The span of control included in the rate models is inclusive of both first- and second- line supervisory staff. ▪ Assumptions included in the IRM were reviewed with stakeholders.
Holiday Adjustment Factor	▪ For certain services, such as residential services that are staffed using a 24/7 staffing model, there is an expectation that that the “typical” staffing model should include some incremental payment for holiday pay.	▪ Holiday pay – a “time and a half” assumption is applied to the underlying average hourly wage for staff for the applicable time. ▪ Residential services - “time and a half” assumption is applied to 2.7% of the total PTO-adjusted time required for the services, which is based on an assumed 10 federal holidays per year. ▪ Assumptions included in the IRM were reviewed with stakeholders.
Caseload Size	▪ Used when the expected costs of services are more reasonably determined on a monthly basis, with resulting accumulated monthly expenses converted to a service unit value based on assumptions related to the average number of individuals served and/or units provided during the month.	▪ CCMA services assume an average caseload size of 35, which was supported by stakeholder feedback during the first stakeholder meeting. ▪ Assumptions included in the IRM were reviewed with stakeholders.

Wage Rate Assumptions for Direct Care Staff and Supervisors

The direct care staff hourly wage for each provider type was developed using May 2021 wage data from the Bureau of Labor Statistics (BLS) for Hawai`i, published in March 2022 (the most recent BLS wage data currently available). BLS wage data was relied upon because they are publicly available, updated on an annual basis, collected in a consistent and statistically credible manner, and provide the most detailed wage information which allows for wage assumptions to vary by region, by wage percentile, and by provider type.

The selection of the BLS wage percentile and annual trend factor was informed by the emerging workforce-specific wage trend, stakeholder feedback, and MQD's intent to maintain a strong workforce in Medicaid to carry out HCBS services in today's inflationary and workforce shortage environment. Figure 13 to the right highlights themes related to wage levels from stakeholder feedback.

Figure 13: High Level Themes Regarding Wage Levels from Stakeholder Feedback:

- Significant pressure on wages due to:
  - Competition from other programs and private sector
  - Employee expectations
  - Workforce shortages that predated COVID
- Difficulty in retaining employees at all levels due to:
  - Impact of COVID on workforce participation
  - Intensity of work in community-based care
  - Limited staffing pipeline between HCBS providers and schools
  - Ability to obtain higher wages with other employers
- Staff are increasingly less experienced due to difficulty in retaining more experienced staff.

Calendar Year 2023 wage levels for purposes of rate calculation were developed using the following steps:

- Obtain the most recent BLS wage data (May 2021) by occupational code and geographic region.
- For each provider type, identify similar BLS occupational categories and their related hourly wages.
- Apply an annual trend factor of 4.22% to the base wage rates, which resulted in an overall 9.39% increase in wages from May 2021 to July 2023.[9]
- Calculate the proposed CY 2023 statewide hourly wage rate for each provider type using the trended wage[s] at 50th percentile for non-supervisor workers.

Figure 14 below summarizes the wage assumptions underlying the rate model along with the wages reported in the provider surveys. The proposed model wages were informed by both the BLS wage data, the provider survey results, stakeholder feedback, and input from MQD. A summary of the wage assumptions included in each rate scenario is provided in Appendix C.

FIGURE 14: WAGE ASSUMPTIONS

		BLS WAGE PERCENTILES			
PROVIDER TYPE	BLS OCCUPATION CODES AND TITLES	25th PERCENTILE	50th PERCENTILE	75th PERCENTILE	PROVIDER SURVEY MEDIAN WAGE
Case Manager	21-1022 - Healthcare Social Workers (25%) / 29-1141 - Registered Nurses (75%)	$ 45.06	$ 53.96	$ 60.65	$41.44
In-Home Attendant	31-1120 - Home Health and Personal Care Aides (75%) / 37-2012 - Maids and Housekeeping Cleaners (25%)	$ 16.12	$ 17.59	$ 19.28	$13.13
Registered Nurse	29-1141 - Registered Nurses	$ 49.48	$ 58.40	$ 66.67	$35.00
Licensed Practical Nurse	29-2061 - Licensed Practical and Licensed Vocational Nurses	$ 24.66	$ 27.23	$ 31.67	$27.08
Nurse Aide	31-1131 - Nursing Assistants	$ 15.45	$ 19.46	$ 20.05	$15.00

[9] The trend factor is based on the Federal Reserve Economic Data (FRED) for Average Hourly Earnings of All Employees, Education and Health Services, and trend adjustments were applied from the BLS reporting period of May 2021, to October 2022. The annualized trend rate utilized for this analysis was 4.22%, which is the geometric mean annualized wage growth rates of FRED data from August 2021 through August 2022 and December 2017 through March 2020 (prior to the public health emergency).

Employee Related Expenses (ERE)

This component captures the ERE expected to be incurred for direct care staff and supervisors for each service. ERE percentages were calculated based on the expected level of ERE as a percentage of direct care staff and supervisor salaries and wages for a given wage region. ERE expenses are calculated as the product of the calculated direct care staff and supervisor salary and wage (described above) and an ERE percentage, which varies by provider group.

Employee related expenses include:

- Employer entity's portion of payroll taxes, employee medical and other insurance benefits
- Employer portion of retirement expenses incurred on behalf of direct care staff and supervisors

A significant portion of the ERE is driven by the cost of health insurance and retirement benefits the employer provides to its employees. MQD recommended a robust ERE to incentivize providers to offer benefits and to support the retention of a skilled workforce. Figure 15 provides a summary of the employee-related assumptions and their related sources. Insurance and retirement costs were sourced from BLS data for the health care and social assistance[10] civilian worker classification.

Figure 15: Employee Related Expense assumptions

COMPONENTS	ASSUMPTIONS FOR CY2023	SOURCE
Employee Social Security Withholding	6.2% Wage Base Limit: $156,000 (as projected by SSA under intermediate scenario)	Internal Revenue Service. Topic No. 751 Social Security and Medicare Withholding Rates. Retrieved from https://www.irs.gov/taxtopics/tc751 Social Security Administration. 2021 Old-Age, Survivors, and Disability Insurance (OASDI) Trustee Report. Retrieved from https://www.ssa.gov/OACT/TR/2021/V_C_prog.html#1047210
Employer Medicare Withholding	1.45%	Journal of Accountancy. Social Security wage base, COLA set for 2022. Retrieved from https://www.journalofaccountancy.com/news/2021/oct/ssa-2022-tax-wage-base-benefit-cola.html
FUTA Tax	$420, 6% of first $7,000	Internal Revenue Service. Topic No. 759 Form 940 – Employer's Annual Federal Unemployment (FUTA) Tax Return – Filing and Deposit Requirements. Retrieved from https://www.irs.gov/taxtopics/tc759
SUI Tax	5.80% Wage Base Limit: $51,600	State of Hawai`i Department of Labor and Industrial Relations – Tax Rate Schedule and Weekly Benefit Amount https://labor.hawaii.gov/ui/tax-rate-schedule-and-weekly-benefit-amount/
Workers Compensation	1.5%	U.S. Bureau of Labor Statistics. National Compensation Survey, September 2021, Employer Costs for Employee Compensation, Historical Listing. Table 12. Private Industry Workers, by Census Region and Division (Pacific Division). Page 491. Retrieved from https://www.bls.gov/web/ecec/ececqrtn.pdf
Insurance Benefits	$7,548 per year ($3.47 base hourly cost for the health care and social assistance industry group multiplied by 2,080 hours, trended from June 2022 to July 2023)	U.S. Bureau of Labor Statistics. (June 2022). Economic News Release, Table 2. Employer Costs for Employee Compensation for civilian workers by occupational and industry group. Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf
Retirement Percent	3.7%	U.S. Bureau of Labor Statistics. (June 2022). Economic News Release, Table 2. Employer Costs for Employee Compensation for civilian workers by occupational and industry group. Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf

The detailed calculations related to the ERE percentage are shown by provider group in Appendix D.

[10] Bureau of Labor Statistics. (September 2022). Employer Costs for Employee Compensation – June 2022. Retrieved from: https://www.bls.gov/news.release/pdf/ecec.pdf

Administration / Program Support / Overhead

An adjustment to account for the cost of administration, program support, and overhead of the provider is built into each of the rate models.[11] The assumption of 20.0% of the total expenses was used for all services, excluding PA1 in-home services. PA1 in-home services uses an assumption of 22.0% to account for supplies that stakeholders reported are often paid for by the provider. A portion of the administrative adjustment assumption is to account for the oversight and time associated with electronic visit verification (EVV). This component is intended to account for the following types of costs:

- **Administrative-related expenses -** Generally, administrative-related expenses would include all expenses incurred by the provider entity necessary to support the provision of services but not directly related to providing services to individuals. These expenses exclude transportation, wages, and employee-related expenses for direct care, and may include, but are not limited to:
  - Salaries and wages, and related employee benefits for employees or contractors that are not direct service workers or first- and second- line supervisors of direct service workers
  - Liability and other insurance
  - Licenses and taxes
  - Legal and audit fees
  - Accounting and payroll services
  - Billing and collection services
  - Bank service charges and fees
  - Information technology
  - Telephone and other communication expenses
  - Office and other supplies including postage
  - Accreditation expenses, dues, memberships, and subscriptions
  - Meeting and administrative travel related expenses
  - Training and employee development expenses, including related travel
  - Human resources, including background checks and other recruiting expenses
  - Community education
  - Marketing/advertising
  - Interest expense and financing fees
  - Facility and equipment expense and related utilities
  - Vehicle and other transportation expenses not related to transporting individuals receiving services or transporting employees to provide services to individuals
  - Board of director-related expenses
  - Translation services
  - EVV administration and oversight
- **Program support costs -** include supplies, materials, and equipment necessary to support service delivery

[11] Overhead percentages reported within the provider survey had wide variation (ranging from 27.5% to 100%) and were determined not to be statistically valid.

The IRM administration, program support, and overhead adjustment considers each of these expenses and is applied as the percent of the final rate that is allocated for these administrative activities.

Transportation

An adjustment to account for the cost of transportation is assumed within the residential and CCMA rate model frameworks. The CCMA rate assumes 400 miles in each month, or approximately 11 miles per person per month with a caseload of 35. Residential stakeholders provided feedback that they deliver infrequent transportation into the community or to doctor's appointments. The residential services rate model framework assumes one 5-mile trip per person per day. Mileage is reimbursed at the Internal Revenue Service standard mileage rate for the final 6 months of 2022 of 62.5 cents per mile.[12]

Stakeholders of in-home services did not indicate that travel was a significant cost of providing services.

Residential Hours

The costs of residential services can vary based on the needs of the individual and staffing needed to support each resident. The IRM supports a rate framework for a residential setting where more than one individual is served, where clinical staff are expected to be on-site for scheduled periods, there is an expectation to provide service coverage on a 24/7 basis, such as the CCFFHs and E-ARCHs of Hawai`i. Residential stakeholders and the provider survey results confirmed that many residential services are provided by nurse aides (NAs) or certified nurse aides (CNAs). There is wide variation in how substitute caregivers are paid for their time, with some substitute caregivers providing their services in-kind or through non-cash reimbursement arrangements. The provider survey results showed combined CNA/NA average direct care time (e.g., face-to-face care) of 36 hours for Level 1 and 42 hours for Level 2 in a three-bed residence. To support a stable staffing model and people with higher acuity, the proposed IRM assumes 42 hours of care for Level 1 and 69 hours for Level 2 in a three-bed residence.

Estimated Payment Impact

We estimated payments under each modeled comparison rate scenario by multiplying modeled rates by the service units in the CY 2021 Medicaid managed care encounter data received from the MCOs via a special feeds extract. We compared modeled comparison rate payments to 2021 baseline payments as follows:

- For in-home and case management services, we summed the reported MCO paid amounts in the CY 2021 Medicaid managed care encounter data.
- For residential services, we multiplied the CY 2021 Medicaid days by CY 2021 QI memo residential rates downloaded from the MQD website.[13] The CY 2021 QI memo rate cohorts were assigned to CY 2021 encounter data based on the reported HCPCS and modifier; in some instances the reported HCPCS and modifier was not included in the QI memo and a rate cohort had to be assumed. This rate cohort crosswalking process was reviewed by MQD for reasonableness.

[12] https://www.irs.gov/newsroom/irs-increases-mileage-rate-for-remainder-of-2022

[13] https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2021/QI-2104A.pdf

Caveats and Limitations

This report is intended for the use of the State of Hawai`i Med-QUEST (MQD) in support of its 2022 Home and Community-Based Services (HCBS) rate study and is not appropriate for other purposes. The terms of Milliman's contract with Med-QUEST signed on July 1, 2020 apply to this this report and its use.

We understand this report will be shared publicly with Hawai`i HCBS stakeholders, including HCBS providers, Medicaid MCOs, and the Hawai`i State Legislature. To the extent that information contained in this report is provided to any approved third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise to not misinterpret the information presented.

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Future alignment of the projected rate and actual HCBS provider experience will depend on the extent to which future experience conforms to the assumptions reflected in the independent rate model. It is certain that actual experience will not conform exactly to the assumptions used in the rate development due to differences in HCBS labor costs, provider efficiency, and many other factors. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose. The models rely on data and information as input to the models. We have relied upon certain data and information provided by MQD and other sources and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Justin Birrell and Rachel Kullman are members of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

Appendix A -
Modeled Comparison Rates

Service Information

Service Description: Case management
Reporting Units: Daily

Ref.	Description	Case Manager	Case Manager - On Call	Total	Notes
A	Hourly wage	$ 53.96	$ 53.96		Based on separate wage build
B	Number of employees	1.00	0.10		
C	**Total wages expense per month**	**$ 9,353**	**$ 935**	**$ 10,288**	C = A * B * 2,080 / 12
D	Employee related expense (ERE) percentage	22.6%	22.6%		Based on separate ERE build
E	**Total ERE expense per month**	**$ 2,115**	**$ 212**	**$ 2,327**	E = C * D
F	Estimated miles driven per month			400	Based on separate travel build
G	Federal reimbursement rate			$ 0.625	
H	**Transportation fleet costs per month**			**$ 250.00**	H = F * G
I	Administration / Program Support / Overhead			20.0%	Portion of monthly costs
J	**Monthly Administrative Expenses**			**$ 3,216.31**	J = I * (C + E + H) / (1 - I)
K	**Monthly Costs**			**$ 16,081.56**	K = C + E + H + J
L	Number of clients per team			35.00	
M	**Daily Rate**			**$ 459.47**	**M = K / L**
N	**Daily Rate**			**$ 15.06**	**N = M / 30.5 days**

Summary of CCMA Rates

Scenario	Service Description	Caseload Size	Direct Service Employee Salaries & Wages	Employee Related Expenses	Transportation & Fleet Vehicle Expenses	Administration, Program Support & Overhead	Total Rate (Monthly)	Total Rate (Daily)
Low	Community Care Management Agency (CCMA)	38	$ 293.96	$ 66.48	$ 7.14	$ 91.89	$ 423.20	$ 13.88
Medium	Community Care Management Agency (CCMA)	35	$ 293.96	$ 66.48	$ 7.14	$ 91.89	$ 459.47	$ 15.06
High	Community Care Management Agency (CCMA)	32	$ 293.96	$ 66.48	$ 7.14	$ 91.89	$ 502.55	$ 16.48

Service Information

Service Description: CCFFH/E-EARCH I - Level 1
Reporting Units: Per Diem

		Primary Caregiver	Substitute Caregiver	Total	Notes
A	**Total weekly hours**	**28**	**14**	**42**	Informed by survey data
B	Number of individuals served			3	The assumed number of clients in the facility
C	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
D	Adjusted total hours of time per week	31.09	15.55		D = A * (1 + C)
E	Hourly wage	$ 19.46	$ 19.46		Based on separate wage build
F	Percent of hours that are third shift	0%	0%		F = ((C * 5 + * 2) * 8) / A)
G	Total wages expense per week	$ 605	$ 303		G = D * (E + F * $0) || Third shift workers get paid an extra $2/hour
H	Holidays/premium pay days worked per year		10.00		
I	Percent of non-holiday hours paid at time and a half		0.0%		
J	Percent of total hours paid at time and a half	0%	2.7%		J = ((365.25 - H) * I + H) / 365.25
K	**Total direct care wage adjusted for overtime and holidays per week**	**$ 605.00**	**$ 306.23**	**$ 911.24**	K = G + A * J * (E + F * $2) * 0.5)
L	Employee related expense (ERE) percentage	38.3%			Based on separate ERE build
M	**Total ERE expense per week**	**$ 231.94**		**$ 231.94**	M = K * L
N	Estimated miles driven per week			105	15 miles per day
O	Federal reimbursement rate			$ 0.625	
P	**Transportation costs per week**			**$ 65.63**	P = N * O
Q	Subtotal before administration / overhead / program support			**$ 1,208.80**	Q = (K + M + P)
R	Administration / program support / overhead percentage			20.0%	
S	**Administration / overhead / program support cost per week**			**$302.20**	S = (Q * R) / (1 - R)
T	**Total cost per week**			**$1,511.00**	T = Q + S
U	Units per week			7.00	
V	**Preliminary Per Diem Rate**			**$71.95**	**V = T / U / B**

Reflects Cost Share rates for Oahu; excludes room and board costs.

SUMMARY OF RESIDENTIAL RATES - LEVEL 1

SCENARIO	SERVICE DESCRIPTION	PRIMARY CAREGIVER WAGE PERCENTILE	SUBSTITUTE CAREGIVER WAGE PERCENTILE	DIRECT SERVICE EMPLOYEE SALARIES & WAGES	EMPLOYEE RELATED EXPENSES	ADMINISTRATION, PROGRAM SUPPORT & OVERHEAD	TOTAL RATE (WEEKLY)	TOTAL RATE (DAILY) - OAHU	TOTAL RATE (DAILY) - NEIGHBOR ISLAND
Low	Residential Services (E-ARCH Type I/CCFFH) - Level 1	25th Percentile	25th Percentile	$ 34.46	$ 9.94	$ 15.01	$ 1,247.65	$ 59.41	$ 64.41
Medium	Residential Services (E-ARCH Type I/CCFFH) - Level 1	50th Percentile	50th Percentile	$ 43.39	$ 11.04	$ 17.52	$ 1,511.00	$ 71.95	$ 76.95
High	Residential Services (E-ARCH Type I/CCFFH) - Level 1	75th Percentile	75th Percentile	$ 44.71	$ 11.21	$ 17.89	$ 1,549.86	$ 73.80	$ 78.80

Service Information

Service Description: CCFFH/E-EARCH I - Level 2
Reporting Units: Per Diem

		Primary Caregiver	Substitute Caregiver	Total	Notes
A	**Total weekly hours**	**47**	**22**	**69**	Informed by survey data
B	Number of individuals served			3	The assumed number of clients in the facility
C	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
D	Adjusted total hours of time per week	51.97	24.88		D = A * (1 + C)
E	Hourly wage	$ 19.46	$ 19.46		Based on separate wage build
F	Percent of hours that are third shift	0%	0%		F = ((C * 5 + * 2) * 8) / A)
G	Total wages expense per week	$ 1,011	$ 484		G = D * (E + F * $0) || Third shift workers get paid an extra $2/hour
H	Holidays/premium pay days worked per year		10.00		
I	Percent of non-holiday hours paid at time and a half		0.0%		
J	Percent of total hours paid at time and a half	0%	2.7%		J = ((365.25 - H) * I + H) / 365.25
K	**Total direct care wage adjusted for overtime and holidays per week**	**$ 1,011.22**	**$ 489.97**	**$ 1,501.19**	K = G + A * J * (E + F * $2) * 0.5)
L	Employee related expense (ERE) percentage	38.3%			Based on separate ERE build
M	**Total ERE expense per week**	**$ 387.68**		**$ 387.68**	M = K * L
N	Estimated miles driven per week			105	15 miles per day
O	Federal reimbursement rate			$ 0.625	
P	**Transportation costs per week**			**$ 65.63**	P = N * O
Q	Subtotal before administration / overhead / program support			**$ 1,954.49**	Q = (K + M + P)
R	Administration / program support / overhead percentage			20.0%	
S	**Administration / overhead / program support cost per week**			**$488.62**	S = (Q * R) / (1 - R)
T	**Total cost per week**			**$2,443.12**	T = Q + S
U	Units per week			7.00	
V	**Preliminary Per Diem Rate**			**$116.34**	**V = T / U / B**

Reflects Cost Share rates for Oahu; excludes room and board costs.

SUMMARY OF RESIDENTIAL RATES - LEVEL 2

SCENARIO	SERVICE DESCRIPTION	PRIMARY CAREGIVER WAGE PERCENTILE	SUBSTITUTE CAREGIVER WAGE PERCENTILE	DIRECT SERVICE EMPLOYEE SALARIES & WAGES	EMPLOYEE RELATED EXPENSES	ADMINISTRATION, PROGRAM SUPPORT & OVERHEAD	TOTAL RATE (WEEKLY)	TOTAL RATE (DAILY) - OAHU	TOTAL RATE (DAILY) - NEIGHBOR ISLAND
Low	Residential Services (E-ARCH Type I/CCFFH) - Level 2	25th Percentile	25th Percentile	$ 56.78	$ 16.61	$ 22.25	$ 1,549.86	$ 95.65	$ 100.65
Medium	Residential Services (E-ARCH Type I/CCFFH) - Level 2	50th Percentile	50th Percentile	$ 71.49	$ 18.46	$ 26.39	$ 2,443.12	$ 116.34	$ 121.34
High	Residential Services (E-ARCH Type I/CCFFH) - Level 2	75th Percentile	75th Percentile	$ 73.66	$ 18.73	$ 27.00	$ 2,507.23	$ 119.39	$ 124.39

Service Information

Service Description: Personal Assistance - Level 1
Reporting Units: 15 minutes

Ref.	Description	Clinician: In-Home Attendant	Supervisor: In-Home Attendant	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	2.00			
C	Average minutes of transportation time per unit	-			Based on separate travel build
D	**Total minutes per unit**	**17.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		1.70		G = D / E / F
H	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**18.88**	**1.89**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 16.12	$ 17.59		Based on separate wage build
K	**Total wages expense per unit**	**$ 5.07**	**$ 0.55**	**$ 5.62**	K = J * I / 60
L	Employee related expense (ERE) percentage	42.4%	40.4%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 2.15**	**$ 0.22**	**$ 2.37**	M = K * L
N	Administration / program support / overhead			20.0%	Portion of total rate
O	Administration expenses - EVV			2.0%	Portion of total rate
P	**Administration Expenses**			**$ 2.26**	P = (N + O) * (K + M) / (1 - (N + O))
Q	**Rate Per 15 minutes**			**$10.26**	**Q = K + M + P**

Summary of PA1 Rates

Scenario	Service Description	Clinician: In-Home Attendant Wage Percentile	Supervisor: In-Home Attendant Wage Percentile	Direct Service Employee Salaries & Wages	Indirect Service Employee Salaries & Wages	Employee Related Expenses	Administration, Program Support & Overhead	Total Rate
Low	Personal Assistance - Level 1	10th Percentile	25th Percentile	$ 4.09	$ 0.55	$ 2.19	$ 1.92	$ 8.75
Medium	Personal Assistance - Level 1	25th Percentile	50th Percentile	$ 4.96	$ 0.66	$ 2.37	$ 2.26	$ 10.26
High	Personal Assistance - Level 1	50th Percentile	75th Percentile	$ 5.42	$ 0.72	$ 2.47	$ 2.43	$ 11.04

Service Information

Service Description: Personal Assistance - Level 2
Reporting Units: 15 minutes

Ref.	Description	Clinician: Nurse Aide	Supervisor: Registered Nurse	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	2.00			
C	Average minutes of transportation time per unit	-			Based on separate travel build
D	**Total minutes per unit**	**17.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		1.70		G = D / E / F
H	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**18.88**	**1.89**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 19.46	$ 58.40		Based on separate wage build
K	**Total wages expense per unit**	**$ 6.12**	**$ 1.84**	**$ 7.96**	K = J * I / 60
L	Employee related expense (ERE) percentage	38.3%	21.9%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 2.35**	**$ 0.40**	**$ 2.75**	M = K * L
N	Administration / program support / overhead			18.0%	Portion of total rate
O	Administration expenses - EVV			2.0%	Portion of total rate
P	**Administration Expenses**			**$ 2.68**	P = (N + O) * (K + M) / (1 - (N + O))
Q	**Rate Per 15 minutes**			**$13.39**	**Q = K + M + P**

Summary of PA2 Rates

Scenario	Service Description	Clinician: Nurse Aide Wage Percentile	Supervisor: Registered Nurse Wage Percentile	Direct Service Employee Salaries & Wages	Indirect Service Employee Salaries & Wages	Employee Related Expenses	Administration, Program Support & Overhead	Total Rate
Low	Personal Assistance - Level 2	10th Percentile	25th Percentile	$ 5.85	$ 0.78	$ 2.50	$ 2.28	$ 11.42
Medium	Personal Assistance - Level 2	25th Percentile	50th Percentile	$ 7.02	$ 0.94	$ 2.75	$ 2.68	$ 13.39
High	Personal Assistance - Level 2	50th Percentile	75th Percentile	$ 7.46	$ 0.99	$ 2.82	$ 2.82	$ 14.10

Service Information

Service Description: Nursing care in home LPN
Reporting Units: 15 minutes

Ref.	Description	Clinician: Licensed Practical Nurse	Supervisor: Licensed Practical Nurse	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	2.00			
C	Average minutes of transportation time per unit	-			Based on separate travel build
D	**Total minutes per unit**	**17.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		1.70		G = D / E / F
H	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**18.88**	**1.89**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 24.66	$ 27.23		Based on separate wage build
K	**Total wages expense per unit**	**$ 7.76**	**$ 0.86**	**$ 8.62**	K = J * I / 60
L	Employee related expense (ERE) percentage	34.2%	32.2%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 2.65**	**$ 0.28**	**$ 2.93**	M = K * L
N	Administration / program support / overhead			18.0%	Portion of total rate
O	Administration expenses - EVV			2.0%	Portion of total rate
P	**Administration Expenses**			**$ 2.89**	P = (N + O) * (K + M) / (1 - (N + O))
Q	**Rate Per 15 minutes**			**$14.43**	**Q = K + M + P**

Summary of Private Duty Nursing - LPN Rates

Scenario	Service Description	Clinician: Licensed Practical Nurse Wage Percentile	Supervisor: Licensed Practical Nurse Wage Percentile	Direct Service Employee Salaries & Wages	Indirect Service Employee Salaries & Wages	Employee Related Expenses	Administration, Program Support & Overhead	Total Rate
Low	Private Duty Nursing - LPN	10th Percentile	25th Percentile	$ 7.39	$ 0.99	$ 2.89	$ 2.82	$ 14.08
Medium	Private Duty Nursing - LPN	25th Percentile	50th Percentile	$ 7.60	$ 1.01	$ 2.93	$ 2.89	$ 14.43
High	Private Duty Nursing - LPN	50th Percentile	75th Percentile	$ 8.44	$ 1.13	$ 3.05	$ 3.15	$ 15.77

Service Information

Service Description: Nursing care in home RN
Reporting Units: 15 minutes

Ref.	Description	Clinician: Registered Nurse	Supervisor: Registered Nurse	Total	Notes
A	Average minutes of direct time per unit	15.00			
B	Average minutes of indirect time per unit	2.00			
C	Average minutes of transportation time per unit	-			Based on separate travel build
D	**Total minutes per unit**	**17.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		1.70		G = D / E / F
H	PTO/training/conference time adjustment factor	11.1%	11.1%		Based on separate PTO build
I	**Adjusted Total minutes per unit**	**18.88**	**1.89**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 49.48	$ 58.40		Based on separate wage build
K	**Total wages expense per unit**	**$ 15.57**	**$ 1.84**	**$ 17.41**	K = J * I / 60
L	Employee related expense (ERE) percentage	23.5%	21.9%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 3.66**	**$ 0.40**	**$ 4.06**	M = K * L
N	Administration / program support / overhead			18.0%	Portion of total rate
O	Administration expenses - EVV			2.0%	Portion of total rate
P	**Administration Expenses**			**$ 5.37**	P = (N + O) * (K + M) / (1 - (N + O))
Q	**Rate Per 15 minutes**			**$26.83**	**Q = K + M + P**

Summary of Private Duty Nursing - RN Rates

Scenario	Service Description	Clinician: Registered Nurse Wage Percentile	Supervisor: Registered Nurse Wage Percentile	Direct Service Employee Salaries & Wages	Indirect Service Employee Salaries & Wages	Employee Related Expenses	Administration, Program Support & Overhead	Total Rate
Low	Private Duty Nursing - RN	10th Percentile	25th Percentile	$ 12.38	$ 1.65	$ 3.63	$ 4.41	$ 22.07
Medium	Private Duty Nursing - RN	25th Percentile	50th Percentile	$ 15.36	$ 2.05	$ 4.06	$ 5.37	$ 26.83
High	Private Duty Nursing - RN	50th Percentile	75th Percentile	$ 18.07	$ 2.41	$ 4.45	$ 6.23	$ 31.16

Appendix B -
Non-Client Facing Time

State of Hawai'i
Department of Human Services
HCBS Rate Analysis – Phase 1
Appendix B - PTO, Training Time, and Non-Productive Time Factor by Provider Group

	A	B	C	D	E	F	G	H	I	J	K	L
Provider Type	**Total Hours**	**Paid Holidays and PTO per year**	**On-going training/ conference time hours per year**	**Total**	**Training hours/inefficient time for each new hire**	**Turnover percentage**	**New hire training hours per year**	**Hours of replacement for non-productive time**	**Annual productive time**	**PTO / training / conference time adjustment factor**	**Additional non-productive time**	**Adjustment factor using additional non-productive time**
				B + C			**E * F**	**D + G**	**A - H**	**A / I - 1**		**A / (I * (1 - K)) - 1**
Case Manager	2,080	160	40	200	20	35%	7	207	1,873	**11.1%**	20.0%	**38.8%**
In-Home Attendant	2,080	160	40	200	20	35%	7	207	1,873	**11.1%**	20.0%	**38.8%**
Registered Nurse	2,080	160	40	200	20	35%	7	207	1,873	**11.1%**	20.0%	**38.8%**
Licensed Practical Nurse	2,080	160	40	200	20	35%	7	207	1,873	**11.1%**	20.0%	**38.8%**
Nurse Aide	2,080	160	40	200	20	35%	7	207	1,873	**11.1%**	20.0%	**38.8%**

Appendix C –
BLS Wages

State of Hawai'i Department of Human Services HCBS Rate Analysis – Phase 1 Appendix C - Wages by Provider Type From May 2021 BLS and Trended to July 2023					
	BLS Hourly Wage Percentiles				
Provider Type	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Case Manager	$ 35.97	$ 45.06	$ 53.96	$ 60.65	$ 64.14
In-Home Attendant	$ 13.11	$ 16.12	$ 17.59	$ 19.28	$ 20.93
Registered Nurse	$ 39.64	$ 49.48	$ 58.40	$ 66.67	$ 68.18
Licensed Practical Nurse	$ 24.15	$ 24.66	$ 27.23	$ 31.67	$ 32.43
Nurse Aide	$ 15.25	$ 15.45	$ 19.46	$ 20.05	$ 24.99

Appendix D –
ERE Buildup

State of Hawai'i
Department of Human Services
HCBS Rate Analysis – Phase 1
Appendix D - Employee Related Expense Buildup (Using 50th Percentile Wage Assumptions)

	A	B	C	D	E	F	G	H	I	J	K	L
Provider Type	**Trended Wage (High-Cost)**	**Annual Employee Salary**	**Medicare**	**Social Security**	**FUTA**	**SUI**	**Workers Comp**	**Insurance**	**Retirement**	**ERE per Employee**	**ERE Percentage**	**Annual Salary and ERE**
Notes	**Trended from 5/1/2021 to 7/1/2023 at a rate of 9.39%**	**A * 2,080**	**B * 1.45%**	**B * 6.2% up to $156,000 estimated taxable limit**	**6% of first $7,000 earned**	**B * 5.80% up to $51,600 estimated taxable limit**	**B * 1.5%**		**B * 3.7%**	**Sum of C through I**	**J / B**	**B * (1 + K)**
Case Manager	$53.96	$112,238	$1,627	$6,959	$420	$2,993	$1,684	$7,548	$4,153	**$25,383**	**22.6%**	**$137,621**
In-Home Attendant	17.59	36,592	531	2,269	420	2,122	549	7,548	1,354	**14,792**	**40.4%**	**51,384**
Registered Nurse	58.40	121,480	1,761	7,532	420	2,993	1,822	7,548	4,495	**26,570**	**21.9%**	**148,050**
Licensed Practical Nurse	27.23	56,645	821	3,512	420	2,993	850	7,548	2,096	**18,239**	**32.2%**	**74,884**
Nurse Aide	19.46	40,470	587	2,509	420	2,347	607	7,548	1,497	**15,515**	**38.3%**	**55,986**

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