

TSG Task Force Update

To: Arkansas Health Reform Task Force

**Re: Follow up from previous Task Force Discussions
and Meetings**

Date: January 20 and 21, 2016

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UPDATE

TSG Guiding Principles for PCMH/Health Home Managed Fee For Service Model for High Cost Populations

At the December 17, 2015 meeting of the Arkansas Health Reform Task Force (TF), the TF voted unanimously in favor of a motion to “ask The Stephen Group to assist the task force to find at least \$835 million in savings without managed care, with the exception of dental.”

The following are a list of the guiding principles that TSG will use in identifying the most appropriate programmatic model to recommend in achieving the baseline savings estimate:

- Savings estimates will be based on an allocation methodology that takes into consideration efficiency, savings and quality across all populations and services, and the savings target will apply only to the entire Traditional Medicaid program, not any individual populations or services
- The savings amount arrived at will assume a growth factor of 5% per year from the FY 2015 baseline spending benchmark
- TSG will set a savings target of in excess of \$835 Million over a five year time period (SFY 2017 to SFY 2021)
- All savings estimates given to the Governor by providers will be independently verified to determine if the model could satisfy the level of savings and if so what initiatives will be included in the recommendation
- The savings target will include all funds and not include any additional revenue due to premium taxes
- The model used will assume a new management structure will be in place for the administration of long term care, behavioral health, developmentally disabled and other high cost populations
- The model that TSG will be developing includes aspects of the DiamondCare plan, to include the linkage of patient centered medical homes to medical, pharmacy and waiver services for the high cost populations (Aged, Blind and Disabled), and will include, among other things, the following services:
 - Independent Assessments
 - Plan of Care
 - Claims payment
 - Utilization Management
 - High Cost Case Management
 - Call Center Services
 - Member Outreach
 - Provider relations
 - Grievances and appeals
 - Quality improvement
 - Robust Info Technology and reporting
- The model may also include:

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- Network development
- Provider credentialing
- Fraud, waste and abuse

- The model will assume State Plan/waiver changes, and may include tiered payments, changes to levels of care, rebalancing and changes to promote least restrictive settings
- The model will recommend a global Section 1115 Waiver and allow for maximum flexibility and federal financial participation
- The model will assume that any contract for similar services currently at DHS will cease to exist at the time the new program/entity and services go live
- The recommended administrative management entity(s) will consist of an entity(s) that will share in both savings and losses – losses including being unable to meet contracted quality outcomes and agreed upon savings estimates
- The management entity will be responsible for achieving a certain portion of the savings and some portion of risk will be shared by providers
- The management entity will also include aspects of the care management of complex Medicaid children cases not currently enrolled in the PCCM program
- There will be recommended the establishment of centers of excellence for certain high cost medical procedures
- Savings will also take into consideration any current efficiency plans by DHS, which may include rule or program changes
- If legislative or rule changes are required to achieve savings, it is assumed that such changes will be accepted by the legislature
- Savings estimates will include savings for enhanced public integrity functions
- Savings estimates will net of any administrative expenses
- The model will recommend the use of some of the savings for the Developmental Disability Wait List Recipients

Savings Baseline

For the purposes of any estimates of savings due to programmatic changes in the traditional Medicaid program, the baseline against which savings will be measured is the SFY 2015 *actual* Medicaid expenditures for the traditional Medicaid population, projected at a 5% annual growth rate, for the 5-year period 2017-2021. The following table shows the aggregate projected expenditures for the traditional Medicaid population for the 2017-2021 period.

SFY	Medicaid Expenditures	Description
2015	\$4,878,786,881	Actuals
2016	\$5,122,726,225	5% annual growth
2017	\$5,378,862,536	
2018	\$5,647,805,663	
2019	\$5,930,195,946	

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2020	\$6,226,705,743	
2021	\$6,538,041,031	
2017-2021 Total	\$29,721,610,919	

Savings Baseline by Group

One of the approaches discussed by the Task Force and recommended by TSG has been the application of care management strategies to certain high cost populations, including the elderly, and those with developmental disabilities and severe and persistent mental illness. The following table breaks out the projected growth in Medicaid expenditures for the 2017-2021 period across several different populations of interest. These projections assume a 5% growth rate, proportional growth across the different populations, and that non-claims based payments are allocated across the groups proportionally.

Projected Traditional Medicaid Expenditures by Group <i>(millions; 5% growth rate)</i>						
Year	2017	2018	2019	2020	2021	2017-2021
Elderly	\$1,542	\$1,619	\$1,700	\$1,785	\$1,874	\$8,520
Developmentally Disabled	\$1,213	\$1,273	\$1,337	\$1,404	\$1,474	\$6,700
Behavioral Health	\$1,202	\$1,262	\$1,325	\$1,391	\$1,460	\$6,639
All other	\$1,423	\$1,494	\$1,569	\$1,647	\$1,729	\$7,862
Total	\$5,379	\$5,648	\$5,930	\$6,227	\$6,538	\$29,722

Impact of Different Growth Rates on Savings

The following tables show the impact on savings from growth rates lower than the 5% growth rate assumed in the baseline scenario. The savings in these tables are calculated against the baseline scenario.

SFY	Medicaid Expenditures	Description	Savings
2017	\$5,378,862,536	Projection from 2015 actuals at 5% growth	\$0
2018	\$5,594,017,038	4% annual growth	\$53,788,625
2019	\$5,817,777,719		\$112,418,227
2020	\$6,050,488,828		\$176,216,916
2021	\$6,292,508,381		\$245,532,650
2017-2021 Total	\$29,133,654,502		\$587,956,418

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SFY	Medicaid Expenditures	Description	Savings
2017	\$5,378,862,536	Projection from 2015 actuals at 5% growth	\$0
2018	\$5,594,017,038	3% annual growth	\$107,577,251
2019	\$5,817,777,719		\$223,760,682
2020	\$6,050,488,828		\$349,077,421
2021	\$6,292,508,381		\$484,083,858
2017-2021 Total	\$29,133,654,502		\$1,164,499,211

Pharmacy Program Savings Architecture and Timing

TSG put forth recommendations for savings in the DHS Medicaid pharmacy program. DHS is already acting on some of those recommendations. In an effort to update the TF, we will describe progress to date, estimated time lines and estimated savings where available.

PDL Expansion

DHS has begun the steps which will result in expanded PDL coverage. Currently, the PDL covers 38% of Medicaid pharmacy claims. Proposed expansion should see the PDL covering 55-60% of claims which approximates the average of 64% for all 24 states reviewed by TSG. The expansion is expected to yield \$9-10 MM in incremental supplemental drug rebates.

The timing of the expansion includes many steps. Currently, DHS contracts directly with drug companies for the supplemental rebates. By joining one of the available multi-state supplemental rebate pools, the contacting effort can be handed over to the multi-state pool administrator, thus freeing up DHS staff to work on other cost avoidance initiatives. DHS is currently evaluating several multi-state rebate pools to determine the best fit. Evaluation is complex in that several factors need to be evaluated and some tradeoffs likely need to be made in selecting the best fit for expanding the PDL. Certainly, rebate yield is a factor, but to qualify for rebates the DHS drug utilization management programs need to align with the terms and conditions in the rebate contracts. In some cases the drug manufacturer may flex rebate requirements, in other cases DHS may need to modify utilization management initiatives on certain drugs. DHS is conducting this evaluation right now, and expects prioritization of the various multi-state rebate pools by the end of January 2016. The next step is to have the State Plan Amendment submitted to CMS by the end of April. Though CMS has a 60 day response timeline and this request will likely be similar to most other states participating in multi-state rebate pools, there could be a delay in CMS response, but as soon as State Plan Amendment is approved the PDL can be expanded.

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Re contract the retail pharmacy network

DHS has also begun the steps necessary to improve the reimbursement methodology with retail pharmacies serving Medicaid beneficiaries in Arkansas. TSG estimated annual savings value between \$0-18.3 MM from decreasing brand ingredient cost reimbursement and dispensing fees for both brand and generic drugs.

Timing of this initiative also includes many steps. The first step is to conduct a CMS-required dispensing fee survey. The data collection part of the survey is complete and results of the survey are expected any day. DHS will also evaluate changing the pricing benchmark used to calculate reimbursement to retail pharmacies. DHS will evaluate NADAC as a replacement for AWP. Evaluating pricing benchmarks is complex and NADAC for example, does not cover every drug product, necessitating an alternative benchmark for some drugs. This is true of other available benchmarks as well. This analysis is expected to be completed by the end of January 2016. Then the State Plan Amendment will be prepared and submitted to CMS for approval by the end of April.

Increase the age for mandatory review of antipsychotic prescription review in children

In its June 2015 update to the Task Force, TSG recommended the expansion of highly effective utilization management of antipsychotic medications prescribed for children. At the time, children 6 and under got a medical review and needed to demonstrate informed consent as well as commit to metabolic monitoring during the course of treatment with antipsychotic drugs. DHS has a plan to incrementally expand the ages of children requiring these interventions. In February 2016 DHS plans to begin reviewing children up to age 7. 8 and 9 year olds are slated to be added in April of 2016. Also in April DHS will propose to the DUR Board expansion up to age 10 and if approved is expected to begin in July. This will be a substantial number of case reviews, so children up to age 12 will not be considered until 2017. The following table represents the opportunity for children over age 6 as well as demonstrating the decrease of both foster and non-foster children using antipsychotics after implementing these reviews.

From July 2008 to July 2015 ***OVERALL DECREASED UTILIZATION OF ANTIPSYCHOTIC DRUGS BY:***

Foster care < 6 yrs of age	85.70%
Foster care 6 - 12 yrs of age	36.03%

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Foster care 13-17 yrs of age	13.50%
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Non-Foster care < 6 yrs of age	94.20%
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Non-Foster care 6 - 12 yrs of age	53.60%
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Non-Foster care 13- 17 yrs of age	26.50%
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Full implementation of medical reviews prior to approving antipsychotics in children up to age 12 will improve care and safety for foster and non-foster children in Arkansas. Those who ultimately stop treatment or who never start protracted treatment amount to significant cost avoidance for DHS.

Hemophilia factor drugs

One of the highest cost classes of drugs paid for by the Medicaid program is Hemophilia factors. The drug class deserves attention for several reasons; the high cost of the products, the high cost of treating patients with bleeding disorders, and the potential for product waste and diversion. Hemophilia factor drugs are already on the CAP list for cost containment, but DHS would reimburse any pharmacy that dispensed these products to eligible beneficiaries. When it comes to managing patients and products like the hemophilia factor drugs, not all pharmacies perform the same. Recognizing this, DHS is in the process of setting performance standards for pharmacies that wish to dispense hemophilia factor drugs to Medicaid beneficiaries. Though any willing provider pharmacy can apply, only those with specific expertise in handling both these products and patients will qualify. Once fully implemented, it is expected that waste will decrease and potential diversion will be stopped. TSG is looking for a way to quantify this cost avoidance.

Vaccinations

In a December 2015 report, "[Outbreaks 2015: Protecting Americans from Infectious Diseases](#)" by the Trust for America's Health and by the Robert Wood Johnson Foundation, the State of Arkansas was ranked for vaccination rates for both influenza and for three recommended pediatric vaccines: measles, mumps and rubella; pertussis/whooping cough; diphtheria, tetanus

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and pertussis; and chicken pox . It is generally accepted that vaccination rates at or above 90% will support population immunity in addition to the individual immunity afforded those who were vaccinated. In this study, two states Arkansas and Colorado failed to hit the 90% threshold for these three childhood vaccines.

Better news with influenza vaccination rate. Along with 17 other states, Arkansas hit the target of vaccinating at least half its population for influenza above age 6 months from fall 2014 to spring 2015. Arkansas' rate was 50.5%.

TSG recommends splitting reimbursement for adult vaccinations into ingredient cost and professional service and reevaluating the professional services reimbursement. For the VFC program TSG recommend reevaluating the professional service reimbursement to better incent vaccinations within the context of a primary care visit. We are currently trying to determine the percent of vaccinations given in Public Health settings vs. all other settings.

Reporting of vaccinations in Arkansas is voluntary and the calculation of the cost of any changes to ingredient cost or professional service fees may be underestimated due to underreporting of vaccine administrations.

Rising costs of prescription drugs

Much has been written about the rising cost of prescription drugs. This is true for new specialty drugs, brand name drugs, and even some generic drugs. There are still examples of declining drug prices, and widely used drugs losing patent protection, but those tend not to make good news stories. In the supply chain of prescription medicines, patients with health insurance paying cost shares and plan sponsors paying the balance together bear brunt of rising manufacturer prices. DHS has several tools to deal with drug cost and drug utilization. The CAP program is just one example and it will be expanded to include many expensive limited distribution specialty drugs in February 2016. TSG has reviewed many plan sponsors' approaches to managing year over year drug trend. Following many years of single digit drug trend growth, the last two calendar years have seen double digit drug trend (10-14% growth year over year). The components of drug trend are drug cost inflation, number of units used, and the mix of medicines used. DHS does a very good job of managing the number of units used (utilization management), the mix of drugs used, and the amount reimbursed for each prescription dispensed by a pharmacy. However, as a plan sponsor, even a public sector payor like DHS, there is virtually nothing that can be done to mitigate the price set by a drug manufacturer. Plan sponsors are left to deal with the prices set at the top of the supply chain.

Integrated Eligibility Systems across States

To meet the tight timeframes and high expectations for transitioning Medicaid to ACA-compliant systems, many states chose to leave other, formerly integrated, programs on their old

systems, at least temporarily, and use enhanced funding opportunities to support changes in Medicaid eligibility rules and processes. The OMB A-87 cost allocation waiver encourages states to allow other human services programs to use systems designed for determining Medicaid eligibility under ACA, without sharing in the common costs of developing those systems. The majority of states have requested and received approval from CMS to use this waiver to develop integrated eligibility and enrollment systems.

Innovations in leveraging ACA implementation to integrate other human service programs include:

- Client portals for eligibility screening tools, multi-benefit online applications with dynamic questions, and self-service case management features
 - Screening: Alabama uses a 6 page survey to provide information to customers on available services and how to apply.
 - Screening: Pennsylvania's COMPASS assesses potential eligibility for a wide variety of programs, many of which are included in the multi-benefit application, and directs consumers to online applications or other options.
 - Screening: Illinois and Virginia's heavily marketed health coverage portals direct applicants likely eligible for Medicaid/CHIP to multi-benefit online application portals to apply for other programs.
 - Multi-benefit applications: Customers may choose which programs to apply for, with questions tailored accordingly, or the questions may be sequenced to relate to certain programs, with the option to answer additional questions to determine eligibility for additional programs.
 - Pennsylvania updated wording and sequencing of application questions to integrate MAGI methods into existing multi-benefit application in COMPASS. COMPASS is also tightly integrated with the separate CHIP application and data is passed between the two systems.
 - Colorado's multi-benefit online application PEAK is updated to incorporate real-time decisions for Medicaid based on MAGI, Child Health Plan and marketplace coverage and subsidies, in addition to continued support for non-MAGI medical and other programs.
 - Kentucky is implementing two online applications - a multi benefit health application based on MAGI and a separate application for other programs - that will be supported by a single underlying eligibility system that shares data entered in either application.
 - Case management: Virginians can see the status of their application/renewal, see benefits they are eligible for, report changes in circumstances (which are routed for processing across relevant programs) and contact their assigned eligibility worker.
 - Case management: Illinois, New Mexico, Colorado also allow clients to view their application status, benefits, make changes and renew. Colorado also allows clients to

- establish eligibility for additional programs by submitting minimal additional or updated information.
- Eligibility systems and business rules engines (BREs) that incorporate rules for multiple health and human service programs and can evaluate information from multiple sources to automate calculations and shorten the eligibility determination process
 - Idaho integrated marketplace coverage and subsidies, and MAGI-based Medicaid and CHIP eligibility determinations into their existing integrated eligibility system that allows SNAP and TANF business rules to be applied to any applicant.
 - New Mexico’s ASPEN eligibility system uses a BRE to automate eligibility, workflow and verification rules and determine eligibility for several programs, as well as advanced premium tax credits.
 - Illinois Integrated Eligibility System (IES) leveraged Michigan’s BRIDGES and New Mexico’s BRE for ACA implementation to process eligibility determinations for all medical, food and cash assistance programs included in their multi-benefit online application.
 - Call center technology that allows states to route calls to appropriate staff and give flexibility for more efficient “virtual” call centers. ACA requires states to offer applications for health care by phone, but some states are integrating other programs as well.
 - Illinois’ call center supports Medicaid, CHIP, SNAP and TANF and allows consumers to submit applications and report changes.
 - Pennsylvania’s virtual call center routes callers to cross-trained staff throughout the state for all COMPASS programs, as well as to specialized and Spanish language call centers.
 - Kentucky’s two 800 numbers (for ACA health coverage only and for other programs) is supported by a single infrastructure and callers can be transferred to representatives at either 800 number as needed, or routed to Tier 2 staff for more complex calls.
 - Electronic data matching to verify eligibility factors. Some states are implementing state hubs to consolidate data and make it easier for workers to access and process information across programs.
 - New Mexico uses state data matching interfaces to support all programs in their integrated system as an alternative to the federal hub.
 - Illinois is integrating existing data match interfaces into its new Integrated Eligibility System so workers do not have to access multiple systems during verification. Verification rules are also programmed into the BRE to automate the determination of when additional documentation is required.
 - Document imaging and management systems to streamline paper document processing across programs and facilitate handoffs among programs or workers.
 - In some states applicants can upload and view documents through the client portal

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- Illinois and Virginia are planning enhanced document management to eliminate paper documents
- Pennsylvania’s new document management system for child support that will be accessible to state and county eligibility workers will be leveraged to support Medicaid program eligibility and was approved for funds through the A87 cost allocation waiver.
- Data management and analytics that merge data from multiple sources (case records and claims databases) and analyze it at case, program, or population level to support better decision-making and improve program operations and client outcomes
 - Kentucky’s data warehouse links individual’s records across health care programs, with plans to link clinical and payers’ claims records to identify gaps in coverage. In the future, the data warehouse will link across non-health care programs.
 - New Mexico’s enterprise master client index will allow comparison of client records across different systems and link them to track individual cases, thereby merging seven distinct program databases into a single repository.
- Mobile tools to help clients better access, use and maintain their benefits or to incorporate into their workflow.
- Colorado’s PEAKHealth mobile app provides users with dynamic provider directory, benefit information, real time digital medical ID cards and the ability to update account information.
- Kentucky’s mobile app for accessing a health care eligibility screener and finding in-person assistance will be expanded to allow consumers to view their application, upload documents and make changes. Kentucky hopes to provide similar mobile tools for non-health programs.

Common themes emphasized during interviews with state representatives included:

- Importance of executive-level leadership and collaboration across involved agencies to provide governance
- Critical role of business process reengineering as driver of technology projects
- Careful consideration how to best capitalize on enhanced federal funding opportunity and cost allocation waiver
- Expectation that data and analytics will help adjust integration for better results and future planning

Source: State Innovations in Horizontal Integration: Leveraging Technology for Health and Human Services, Center on Budget and Policy Priorities, March 2015:

<http://www.cbpp.org/sites/default/files/atoms/files/3-23-15fa.pdf>

Specific State “Best Practice” in HHS systems integration

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North Carolina

- Families Accessing Services through Technology (NC FAST) integrates 19 legacy systems
- Integrates 17 DHHS programs, including Child Care, Food and Nutrition, Medicaid, Work First, Energy Assistance, Special Assistance, Refugee Assistance. Additional programs in Child Services and Aging and Adult Services to be implemented by 2017.
- Projects include Case Management Integration, ePASS, Document Management, Online Verification, Service Delivery Interface
- Implemented on Curam. First phase implemented 2012 to provide global case management and SNAP services. Additional successful implementation completed to process Medicaid applications in the counties, TANF, Special and Refugee Assistance, and MAGI Medicaid.
- Counties have tools to share information and track cases across program areas and county lines
- The State has access to current, accurate and useful data integrated across programs
- The State has comprehensive data on service delivery for accountability and decision-making
- Statewide Identity Management Solution (NCID) across departments and services is used by DHHS to access the citizen portal, ePass, and DHHS Human Service programs
- Pilot with MorphoTrust to create an e-ID for online transactions to replace transactions normally done in person (goal is to replicate Driver's License as trusted valid ID)
- Awards
 - 2014 National Information Exchange Model (NIEM) award winner for projects that demonstrate how intergovernmental collaboration and innovative technology improve performance, efficiency and transparency
 - 2012 Quality Program Award from National Staff Development and Training Association, APHSA
 - 2012 Finalist for North Carolina Technology Association (NCTA) 21 Award to a non-technology company for Best Implementation of Technology Award
 - 2011 Enterprise Ireland Award for Innovation in Social Enterprise Management at Curam Software International User Conference
- Fraud Detection (From eWeek article at : <http://www.eweek.com/c/a/Health-Care-IT/IBM-Predictive-Analytics-Helps-North-Carolina-Detect-Medicaid-Fraud-106974>)
 - IBM predictive analytics software (FAMS) used to analyze Medicaid and provider claims for suspicious billing patterns
 - IBM InfoSphere Identity used to resolve identity conflicts based on shared attributes and characteristics

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Source: Program Status Report to Legislature and Overview as of 2013, with budget and timeline, at:

[http://www.ncleg.net/documentsites/Committees/HouseAppropriationsIT/2013%20Session/03-07-2013/North%20Carolina%20Familles%20Accessing%20Services%20through%20Technology%20\(NCFAST\).pdf](http://www.ncleg.net/documentsites/Committees/HouseAppropriationsIT/2013%20Session/03-07-2013/North%20Carolina%20Familles%20Accessing%20Services%20through%20Technology%20(NCFAST).pdf)

Program Overview: <http://www.nciom.org/wp-content/uploads/2010/10/Vellucci-HBE-NC-FAST-High-Level-Overview-with-ePASS-101910.pdf>

New Mexico

- Automated System Program and Eligibility Network (ASPEN), implemented 2013-2014
- Based on Michigan Dept. of Human Services Bridges eligibility system developed by Deloitte.
- ASPEN determines eligibility for all state-administered programs, including SNAP, TANF, State Cash Assistance, Refugee Cash, Low-Income Home Energy Assistance Program, Medicare Savings Program, and Medicaid (around 20 categories)
- ASPEN also has modules for all agencies business units, such as: Restitutions, Fair Hearings, Supervisor reviews, reporting, work programs for SNAP and TANF, and Investigations. Different user roles for system users allow access to only specific modules as defined by the state.
- Self-service website to apply for benefits online and access case information: The system functions for initial application, recertifications, case changes, correspondence and basic case maintenance. All program eligibility is available for each beneficiary and maintains historical case data as well as issuances. The programs have some automated rules to consider eligibility based on the receipt of other programs (such as the relationship between countable Cash assistance towards SNAP benefits, etc.).
- “All in all it has been a huge success.”
- Implementation Challenges:
 - Aggressive timeline for requirements/design was met by using the best from field offices
 - Ensuring no requirements missed in the massive amounts of requirements
 - Getting the business experts providing input to jettison the old and replace it with the potentials of the new
 - During rollout, getting seasoned workers to trust the new system: change was from a legacy code based system to a rules-based system that determined eligibility
 - Seasoned workers adjusting to moving slower due to larger amount of data collection.
- Technical Challenges and Advice

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- Data conversion was a larger effort than anticipated and legacy vendor had a lot of work not planned for – be clear on who is doing what in this area before signing a contract.
- Reports – need testing with live data prior to sign off.
- Interface partner testing – need devoted technical, vendor and business to make this happen – earlier than later and with live data, not mocked up.
- Get your notices cleaned up before converting to new system – we’ve redone ours many times since go Live for reasons not related to the system and it has been expensive work.
- Assume your technical folks will have to devote quite a bit of time depending on intent for M&O, knowledge transfer, etc.
- Code base was not ‘modern’. We did transfer from another state that had transferred from another state – the technology is stale and tacking on makes for challenges in supporting and changing downstream.
- Advice: “NM devoted a large team of persons from the field and central office and didn’t spare the best and the brightest, I believe this was one of the most crucial things done to insure success.”

Source: Report to Legislative Finance Committee, October 2013 (detailed report including funding, cost estimates and recommendations):

[http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/Human%20Services%20Department%20-%20Automated%20System%20Program%20and%20Eligibility%20Network%20\(ASPEN\).pdf](http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/Human%20Services%20Department%20-%20Automated%20System%20Program%20and%20Eligibility%20Network%20(ASPEN).pdf)

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Pennsylvania: Commonwealth of Pennsylvania Application for Social Services (COMPASS)

- Provides single access point for application for Health Care Coverage (Medicaid, Medicare Savings, CHIP, and Health Insurance Marketplace), SNAP, Cash Assistance, LTC, Home and Community based services for individuals with intellectual disabilities, LIHEAP, Free or reduced price school meals, Child Care Works.
- Developed by Pennsylvania Department of Public Welfare
- Direct link to Healthy Kids Hotline to allow callers to receive over-the-phone application assistance in the moment, with hotline staff submitting needed information
- Performs high level eligibility screening and routes application to proper program. COMPASS has integrated MAGI methods into its application and exchanges data with other online eligibility systems.

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- Includes a streamlined “Power User” version without ‘bells and whistles’ and help screens to allow registered Community Partners to quickly help applicants
- Includes e-signature process for individual applicants
- Allows individuals to submit verification documents electronically.
- Post-eligibility screening notifies applicants to non-health programs if they may be eligible for Medicaid/CHIP and offers opportunity to add health care coverage to their application
- Begun in 2001 to provide joint application to Medicaid and CHIP, COMPASS has been expanded over the years to include other programs.
- In 2003, COMPASS earned first place in the Center for Digital Government’s Best of Web competition for innovations in State General Government. In 2002, West Virginia replicated the system in 6 months. Several other states have also leveraged COMPASS concepts and approaches in developing their own Self Service applications.
- Lessons learned:
 - No matter how simple a particular enrollment or renewal strategy may seem, it will never work for everyone. There must be a range of mechanisms and choices available.
 - Flexibility to make mid-course process corrections is key.
 - Small scale testing of new practices enabled development of workable structures for moving forward.
 - Community and consumer advocates play a critical role in securing on-going improvements. The recommendation for the “Power User” version of COMPASS, for example, came from a local Covering Kids and Families pilot site.

Sources: Overview at

<https://www.compass.state.pa.us/Compass.Web/MenuItems/LearnAboutCompass.aspx?language=EN>

Georgetown University 2008 Overview: <http://ccf.georgetown.edu/wp-content/uploads/2008/02/Pennsylvania-Streamlined-Enrollment.pdf>

Ohio

- Ohio Benefits was developed by Accenture and implemented in 2013, focusing initially on Medicaid eligibility and expansion.
- During fiscal years 2016 and 2017, eligibility determination for additional income-tested programs will transition to the Ohio Benefits platform, including Medicaid for the ABD, SNAP, TANF, WIC and Child Care.
- Will provide a single platform that allows individual programs to have their own distinct policy rules while sharing data across platforms. Completed system will simplify enrollment and disability determination.

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- Will allow county Jobs and Family Services Offices to adopt a shared services model and process any case, regardless of geographic boundaries.
- Will seamlessly combine eligibility data across Medicaid, SNAP, TANF, WIC and Child Care, as well as integrate other data such as Medicaid claims and early childhood data
- A holistic view of services Ohioans are receiving will enabling comprehensive case management and allow data driven decisions and objective measurement of the effectiveness of policies
- Simplifies Disability Determination by combining eligibility determination for Medicaid and SSI

Sources

Transformation Office Overview - Simplify Eligibility Determination, April 2015:

<http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=hSAAEHhkLjA%3D&tabid=252>

Accenture overview of project: https://www.accenture.com/t20150523T032534_w_us-en/acnmedia/Accenture/Conversion-Assets/Microsites/Documents11/Accenture-State-Of-Ohio-Integrated-Eligibility-System-v2.pDF

Minnesota

- Health Insurance Exchange (HIX) provides support for eligibility, enrollment and case management for MNsure, Minnesota's single portal for health care coverage and premium assistance.
- Curam software used to evaluate eligibility for Medicaid, advanced premium tax credit, and other cost sharing reduction programs.
- Vision for integrated service delivery across programs and service domains was outlined in 2014
- Currently in production status of MNsure IT System, and adding needed functionality for case management and public program support – 2 year timeline
- Integrated Service Delivery System will also incorporate the MNsure IT system. This project is in planning and early development, with first phases of development funded – 5+ year timeline

EEF and DHS Response to Gartner Report

TSG met with Tim Lampe and Mark White on January 14, 2016 to discuss activities related to the Gartner Report and the EEF project.

Observations to Date

DHS has begun work on all seven projects defined in the Gartner Report. These include:

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Project #1 – Halting Cúram Deployment until Foundational Capabilities and Infrastructure are in place

Project #2 – Define/Ratify and Promote State’s Health and Human Services Vision

Project #3 – Enhance Investment and Program Governance and Management

Project #4 – Develop Strategic Sourcing and Vendor Management Capabilities

Project #5 – Define and Implement Architecture, Vision, Standards and Methodologies

Project #6 – Competitive Procurement System Integrator Services

Project #7 – Enhance Communications and Organizational Change Management Processes

Highlights of these projects include:

Overall

DHS is using internal staff and Cognisante Project Management Organization (PMO) resources to create project charters and detailed work plans for each of the seven projects listed above. Gartner will support DHS on only one of the seven projects – the new Competitive Procurement for System Integrator Services. Gartner has not yet started this work.

DHS has held a kickoff call for all this work and will hold a formal kickoff meeting on January 21. DHS has indicated that it is willing to update TSG on the status of the meeting and activities to provide the Task Force with on-going information, and TSG will also offer technical consultation to DHS, if requested and approved by the Task Force.

DHS has pulled a DIS resource – the former User Acceptance Test Lead – to focus on these projects.

DHS has also released an RFP for PMO services to competitively bid the work that Cognisante is currently doing on a sole-source basis. DHS has pulled Cognisante resources from a variety of existing projects to piece together a team to assist with these seven projects in advance of awarding the PMO services to a competitively bid vendor.

Project #1

DHS has terminated the contract with RedMane for SNAP work. They have stopped the Northrup Grumman work associated with SNAP and they have stopped the work of one independent contractor associated with this effort.

DHS will continue to use eSystems, under the old contract structure, for the next six months on the Design Develop and Implement (DDI) work that CMS wants. eSystems will provide

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application maintenance services on the existing Cúram product and application and operational support to run batches to perform necessary work to support EEF processes.

DHS will rename the new project to reflect the substantial changes that are being made to improve this effort. The new effort will be the Integrated Eligibility Benefit Management System.

Project #2

The Governor has chosen members of the overall visioning board to define/ratify the State's Health and Human Services vision. They will consider the issues of integration of child support and TANF as previously raised.

TSG is not aware of the timing of this board's meetings.

Project # 3

The PMO will take the lead on this project.

Project #4

Tim Lampe and the PMO will take the lead on this project.

Project #5

The new DHS CIO, Jeff Dean, will take the lead on this project.

Project #6

Gartner will support DHS on this competitive procurement for systems integrator services. DHS is responsible for defining the requirements in this procurement. The timeline for this project remains consistent with the timeline shown in the Gartner Report. DHS will take the existing requirements from their current EEF project documentation and update them. They will involve their key stakeholders to verify the requirements are correct and complete. Gartner will assist in writing the other portions of the RFP. DHS will follow proper protocol in having CMS review the RFP prior to publishing it. DHS anticipates it will be mid-summer before this RFP is advertised to potential vendors. Evaluation of proposals would occur in October/November and final CMS review and contract negotiations would occur in November/December. DHS expects to receive bids from some vendors who will propose using the Cúram product and other vendors who will propose other technical platforms. They ultimately believe CMS may make the decision on technical direction.

Project #7

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Tim Lampe is leading this organization change work with support from the PMO. Ultimately, he will involve all the appropriate DHS divisions.

Summary of Michigan 1115 Medicaid Expansion Demonstration Waiver approved December 2015

Health Michigan Plan Demonstration Waiver implemented April 2014, extended through December 2018.

- Medicaid coverage to all (approx. 600,000) newly eligible adults with income up to 138% FPL
- Beneficiaries are required to make monthly payments into health savings accounts based on average co-payments over previous 6 months (at state plan amounts)
- Beneficiaries at 100-138% FPL are required to make monthly premium payments not to exceed 2% of income to health savings accounts, beginning in month 7 of coverage
- Beneficiaries will be notified of co-payments liability by providers at time of service, but billed for copayments quarterly.
- Health savings account payments above 2% of income can be reduced through compliance with specified healthy behaviors (including health risk assessment)
- Combined family premiums and cost-sharing may not exceed 5% of family income
- Pre-existing MCOs and Pre-paid Inpatient Health Plans (PIHP) are used for mental health and substance abuse services for the newly eligible populations.
- Failure to pay premiums or contributions does not affect eligibility, enrollment or access to services
- Health plans are responsible for covering the “first dollar” expenses up to an amount based on a beneficiaries annual expected contribution (\$1000 – contribution = Health Plan coverage). Funds in the MI Health Account are capped at \$1000. MI Health Accounts may accept third party contributions on behalf of beneficiaries up to the capped amount.

December 2015 amendment to Healthy Michigan Plan, to be implemented April 2016

- Beginning in April 2018 members with incomes above 100% FPL and not medically frail must choose between a Qualified Health Plan offered on the marketplace (with premium assistance and cost-sharing subsidies) or continue Medicaid coverage under a Healthy Michigan Plan
- Beneficiaries under the Healthy Michigan Plan must undergo a health risk assessment and meet healthy behavior requirements.
- Michigan must submit by July 2017 a list of healthy behaviors with which beneficiaries will be required to comply, which may not be more restrictive than the current list.
- The new requirements will apply to approximately 100,000 of the 600,000 eligible population.

Waiver proposals denied by CMS or approved with changes

- A request to increase premiums up to 3.5% of income and increase cost sharing up to 7% of family income (with the opportunity for reductions) for beneficiaries above 100% FPL who are enrolled in Healthy Michigan was denied by CMS.

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- Michigan requested that type of coverage and cost-sharing obligations be based on the time a beneficiary has been enrolled, with the choice of coverage and increased cost-sharing kicking in after 48 months of Medicaid enrollment. However, CMS approved that all beneficiaries above 100% FPL be given the choice beginning in April 2018 (48 months after implementation of the amended Health Michigan demonstration project).

The current Health Risk Assessment includes:

- 9 Questions on overall health, exercise, diet, alcohol and tobacco use, stress, use of mood enhancing drugs or meds, flu vaccine, last doctor's visit.
- The final portion of the health risk assessment is completed by the primary care provider and includes attestations by the provider that the member has acknowledged changes in behavior that may need to be made, the members' willingness/ability to address those behaviors, and basic health screening information.
- Initial appointments with PCPs within 60 days of enrollment are encouraged, but not required; however the completion of the HRA at the initial appointment can result in incentive credits.
- Incentives are also paid to providers for completing HRAs with Healthy Michigan Plan members

Sources:

The CMS Special Terms and Conditions Document includes details of the waiver, including the Healthy Behaviors Incentives Program Protocol: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf>

Modern Health, December 17, 2015

<http://www.modernhealthcare.com/article/20151217/NEWS/151219876>

Manatt on Medicaid, December 23, 2015 <https://www.manatt.com/medicaid-update/Manatt-on-Medicaid-CMS-Approves-Michigans-Waiver.aspx>

Kaiser Family Foundation Fact Sheet on Michigan, November 2015, <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/>

State Medicaid Dental Programs

Below is a breakdown of each of the state dental programs according to the level of coverage for adult populations and the program model – based on the following definitions.

Level of Adult Coverage:

1. Extensive: These state programs cover preventive dental services and frequently offer coverage for restorative, oral surgery, and/or periodontal services as well. A handful of dental services are offered.

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2. **Limited:** These states allow preventive treatments, but typically only cover one or two services.
3. **No coverage:** These states cover no dental services for adults, or are so limited in their coverage that most adult beneficiaries cannot receive dental services. (For example: In Maryland, limited dental coverage is an optional value-add for MCOs for adults over 21, and pregnant women receive comprehensive dental benefits from the state program.)

Dental Program Models:

1. **Dental Managed Care—Incentive-based:** These states carve out their Medicaid dental program and partner with a dental vendor to administer the program. Vendors assume full or shared financial risk.
2. **Third Party Administrator—Administrative Services Only:** These states carve out their Medicaid dental program and partner with a dental vendor to administer the program. The dental vendor does not assume financial risk.
3. **Medical Managed Care:** These states do not carve out their Medicaid dental programs. Instead, Medicaid managed care organizations (MCOs) are required to offer Medicaid dental coverage as part of a comprehensive package of Medicaid benefits. Many MCOs subcontract with a dental benefits vendor to administer dental services.
4. **State-Administered:** These states administer their Medicaid dental programs and usually do not partner with managed care organizations or dental benefits administrators.
5. **Dental ACOs (OR only):** In Oregon, a network of health care providers (physical health care, addictions and mental health care providers) serve those receiving coverage under the Oregon Health Plan (Medicaid). These Coordinated Care Organizations partner with Dental Accountable Care Organization, known as dental care organizations (DCOs) to administer the Medicaid dental program. These provider organizations are at full financial risk.

State	Level of Adult Coverage	Dental Program Model
Alabama	No adult coverage	State-Administered
Alaska	Extensive coverage	Medical Managed Care
Arizona	No adult coverage	Medical Managed Care
Arkansas	Limited coverage	State-Administered

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California	Extensive coverage	Third-Party Administrator: ASO
Colorado	Limited coverage	Third-Party Administrator: ASO
Connecticut	Extensive coverage	Third-Party Administrator: ASO
Delaware	No adult coverage	State-Administered
Florida	Emergency coverage only	Medical Managed Care
Georgia	Emergency coverage only	Medical Managed Care
Hawaii	Emergency coverage only	Third-Party Administrator: ASO
Idaho	Emergency coverage only	Dental Managed Care
Illinois	Limited Coverage	Medical Managed Care and Third-Party Administrator: ASO ¹
Indiana	Limited Coverage	Medical Managed Care
Iowa	Extensive coverage	State-Administered ²
Kansas	Limited Coverage	Medical Managed Care
Kentucky	Limited Coverage	Medical Managed Care

¹ Illinois is transitioning from an ASO dental carve out model to including dental as a benefit offered by the medical managed care plans.

² Adult expansion populations are administered by a dental vendor under a separate program called the Dental Health and Wellness Program.

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Louisiana	Limited Coverage	Dental Managed Care
Maine	Emergency coverage only	State-Administered
Maryland	No adult coverage	Third-Party Administrator: ASO
Massachusetts	Extensive coverage	Third-Party Administrator: ASO
Michigan	Limited Coverage	State-Administered and Dental Managed Care
Minnesota	Limited Coverage	Medical Managed Care
Mississippi	Emergency coverage only	State-Administered
Missouri	Emergency coverage only	Medical Managed Care
Montana	Emergency coverage only	State-Administered
Nebraska	Limited Coverage	State-Administered
Nevada	Emergency coverage only	Medical Managed Care
New Hampshire	Emergency coverage only	State-Administered
New Jersey	Extensive coverage	Medical Managed Care
New Mexico	Extensive coverage	Medical Managed Care
New York	Extensive coverage	Medical Managed Care
North Carolina	Extensive coverage	State-Administered
North Dakota	Extensive coverage	State-Administered

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Ohio	Extensive coverage	Medical Managed Care
Oklahoma	Emergency coverage only	State-Administered
Oregon	Extensive coverage	Dental ACO
Pennsylvania	Limited Coverage	Medical Managed Care
Rhode Island	Extensive coverage	State-Administered
South Carolina	Limited Coverage	Third-Party Administrator: ASO
South Dakota	Limited Coverage	State-Administered
Tennessee	No adult coverage	Dental Managed Care: Risk-Share
Texas	Emergency coverage only	Dental Managed Care
Utah	Emergency coverage only	Third-Party Administrator: ASO
Vermont	Limited Coverage	State-Administered
Virginia	Limited Coverage	Third-Party Administrator: ASO
Washington	Extensive coverage	State-Administered
West Virginia	Emergency coverage only	State-Administered
Wisconsin	Extensive coverage	Medical Managed Care
Wyoming	Limited Coverage	State-Administered

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*In more cases, states offer the same type of dental coverage to all adult Medicaid enrollees. However, Montana offers extensive coverage to adults with disabilities and other special needs and emergency-only coverage to all other adults over 20. North Dakota offers extensive coverage to its traditional Medicaid base, but no coverage to its expansion population. Idaho offers limited dental benefits beyond emergency care to pregnant women and adults with disabilities and other special needs.

For more details on the specific services each state offers for adults, the link below (page 29-30) breaks down each state's benefits into categories: emergency only, preventive, restorative, oral surgery, orthodontia, dentures, and periodontal services. Unfortunately this document isn't the most up-to-date.

<https://www.macpac.gov/wp-content/uploads/2015/06/Medicaid-Coverage-of-Dental-Benefits-for-Adults.pdf>

Dental Managed Care – Incentive based

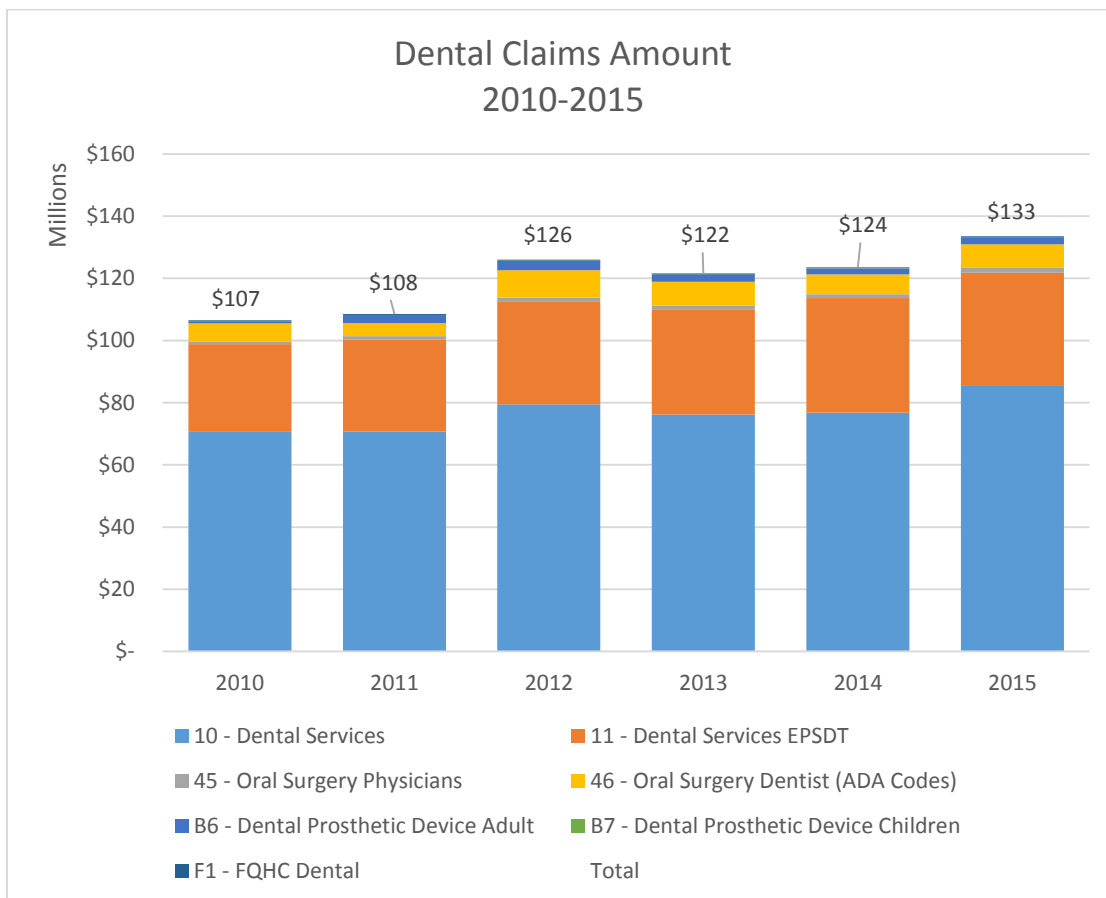
Dental Managed Care contracts in states would include the following requirements:

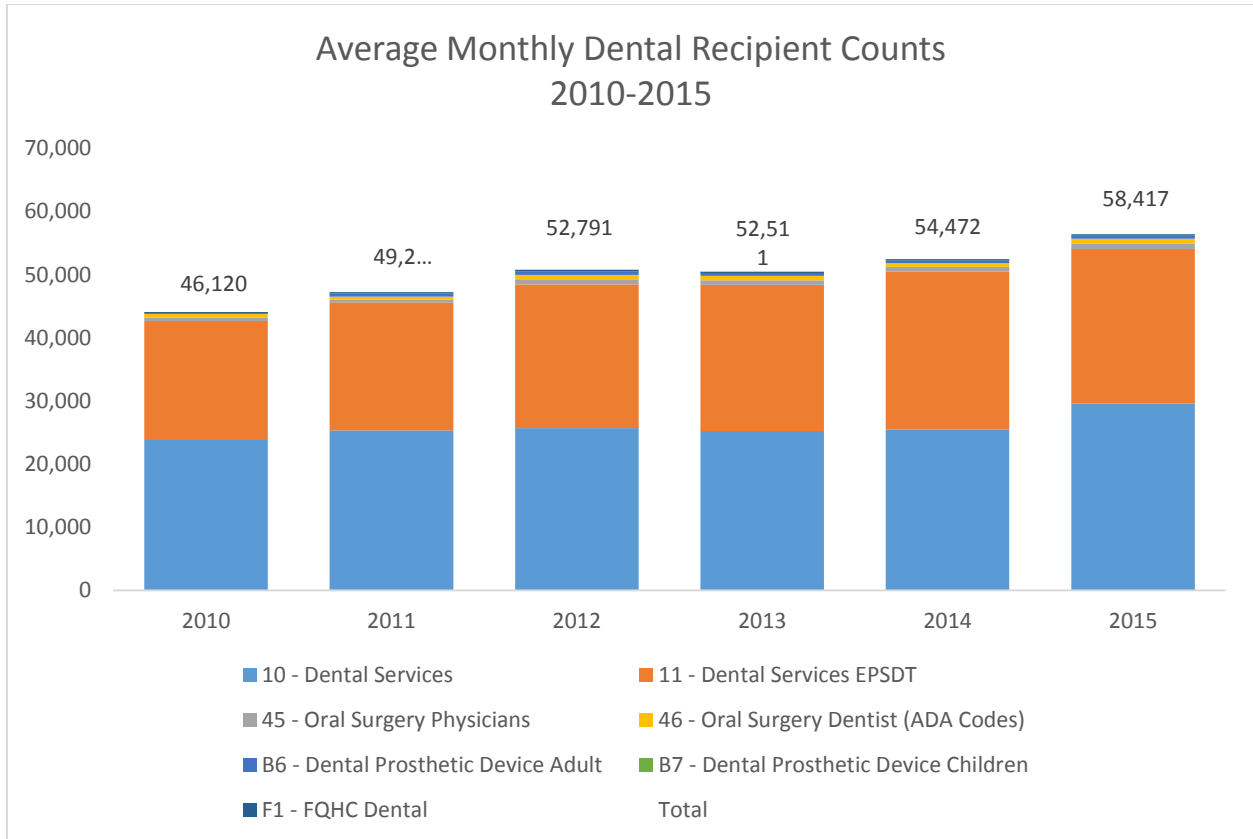
- Administration of all Medicaid dental benefits on a full risk capitated basis. In this case the state would compensate the dental managed care organization (MCO) using an actuarially sound per member per month rate that is set forth in an RFP and the process would be competitively bid (CMS requirement).
- CMS would probably also require at least two companies selected to cover the entire state to allow for freedom of choice among providers.
- Providers would be compensated on a fee for service based by the dental MCO
- The RFP would include a dental home for all enrollees in the plan and would include the following critical elements:
 - Claims payment
 - Credentialing
 - Utilization management
 - Case management
 - Call center
 - Network development
 - Member outreach and education
 - Grievances and appeals
 - Quality improvements
 - Information technology
 - Fraud, waste and abuse protection

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- The RFP will also require that the dental MCO managed the dental program applying nationally accepted clinical guidelines for utilization management and also have a full plan of accreditation from the National Committee for Quality Assurance (NCQA) and ensure continuous quality improvement.
- The RFP should include incentives to meet benchmark cost savings within the program, provide for full risk in not meeting the benchmark and also allow for shared savings arrangements where there is the promotion of access and quality prevention services.

DHS Dental Claims History – 2010 to 2014





Section 1332 Waiver Review

The Patient Protection and Affordable Care Act (PPACA) established a new type of waiver that states can pursue. The Section 1332 waiver allows states to request waivers of certain provisions of PPACA, beginning in 2017. Section 1332 waivers allow for states to waive provisions of PPACA relating to the individual mandate, employer mandate, benefits and subsidies, and marketplaces and qualified health plans. Provisions that may not be waived by Section 1332 waivers include the prohibition on medical underwriting using pre-existing conditions, rating bands, guaranteed issue, and numerous other provisions. In order to be considered, a 1332 waiver must enable coverage at least as comprehensive as marketplace coverage and as affordable to individuals as marketplace coverage, cover at least as many people as PPACA without the waiver, and not increase the federal deficit.

Recent State Activity Regarding 1332 Waivers

As of December 2015, six states had enacted legislative measures related to 1332 waivers: Hawaii, Minnesota, Ohio, Rhode Island, and Texas. The intent and binding nature of these bills

vary considerably. [Source: National Conference of State Legislatures; Health Innovation Section 1332 Waivers: State Legislation as of 2015]

State	Bill/Status	Summary
Hawaii	2015: H 576 Passed signed 7/1/2015 as Act No. 2015184	Provides resources to develop a 1332 waiver from certain provisions of the ACA. Act 158 of 2014, established a state innovation waiver task force to develop a health care reform plan that meets the requirements for obtaining a state innovation waiver that complies with the ACA. The plan to be developed by the task force for the waiver is expected to build on the success of chapter 393, Hawaii's Prepaid Health Care Act.
Minnesota	2015: S 1458; passed signed 5/22/2015 as Ch. 71	Requires the governor to convene a task force on health care financing to advise the governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans. "The task force shall consider opportunities, including alternatives to MNsure, options under section 1332" of the ACA, and options under a section 1115 waiver.
Ohio	2015: H 64 passed; signed 6/30/2015, PL 2015-141	Budget section, provides that the superintendent of insurance shall apply to the United States secretary of health and human services and the United States secretary of the treasury for an innovative waiver regarding health insurance coverage in this state as authorized by section 1332 of the ACA. The superintendent shall include in the application a request for waivers of the employer and individual mandates in sections. The application shall provide for the establishment of a system that provides access to affordable health insurance coverage for the residents of this state.
Rhode Island	2105: H 5900 Passed; signed 6/30/2015	Provides that to "take advantage of economies of scale and to lower costs, the exchange is hereby authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver."
Texas	2105: H 2304; passed House and Senate; signed 6/17/2015 as Ch. 837	The Health and Human Services Commission "shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care. [...] (c) The operational plan under this section may evaluate: [...] Section 1332 of 42 U.S.C. Section 18052 [...]"

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New Federal Guidance on Section 1332 Waivers

In December 2015, the U.S. Department of Health and Human Services issued guidance on the 1332 waivers that was widely perceived as narrowing their applicability. The guidance precludes achieving budget neutrality across waivers (e.g., by including 1115 and 1332 waiver expenditures and savings within the same budget neutrality calculation). The guidance also makes explicit that the federal exchange will not be able to accommodate differential state policies, including 1332 waivers, so state policies pursued under a 1332 waiver may require the operation of a state exchange. The guidance also appears to preclude eliminating individual and employer mandates due to the inability of IRS to accommodate differential state policies.