Bureau of Legislative Research

# Arkansas Health Care Reform Task Force

TSG Update Report #2

July 15, 2015





THE STEPHEN GROUP

# Carriers and DHS has provided claims data files

- Claims, Beneficiaries and Providers
- DHS, QualChoice, Novosys and Blue Cross
- Data is loaded into a secure system at the BLR
- TSG is well into data cleansing—which is the step before analysis

# Data has a few issues; we are working with the carriers and DHS

- Many instances of multiple Medicaid Id #s for the same person
- Many different eligibility & termination dates (up to 35)
- 9999 as termination year
- Medicaid Id #s used for different people
- No income data
- No Medicaid id # (Blue Cross)
- Charge codes other than standard DRG codes
- Outlier ages (<1984 and >2015)
- Provider codes without explanation
- One of the carriers seems to have doubled the claims—probably a good reason for presenting the data this way

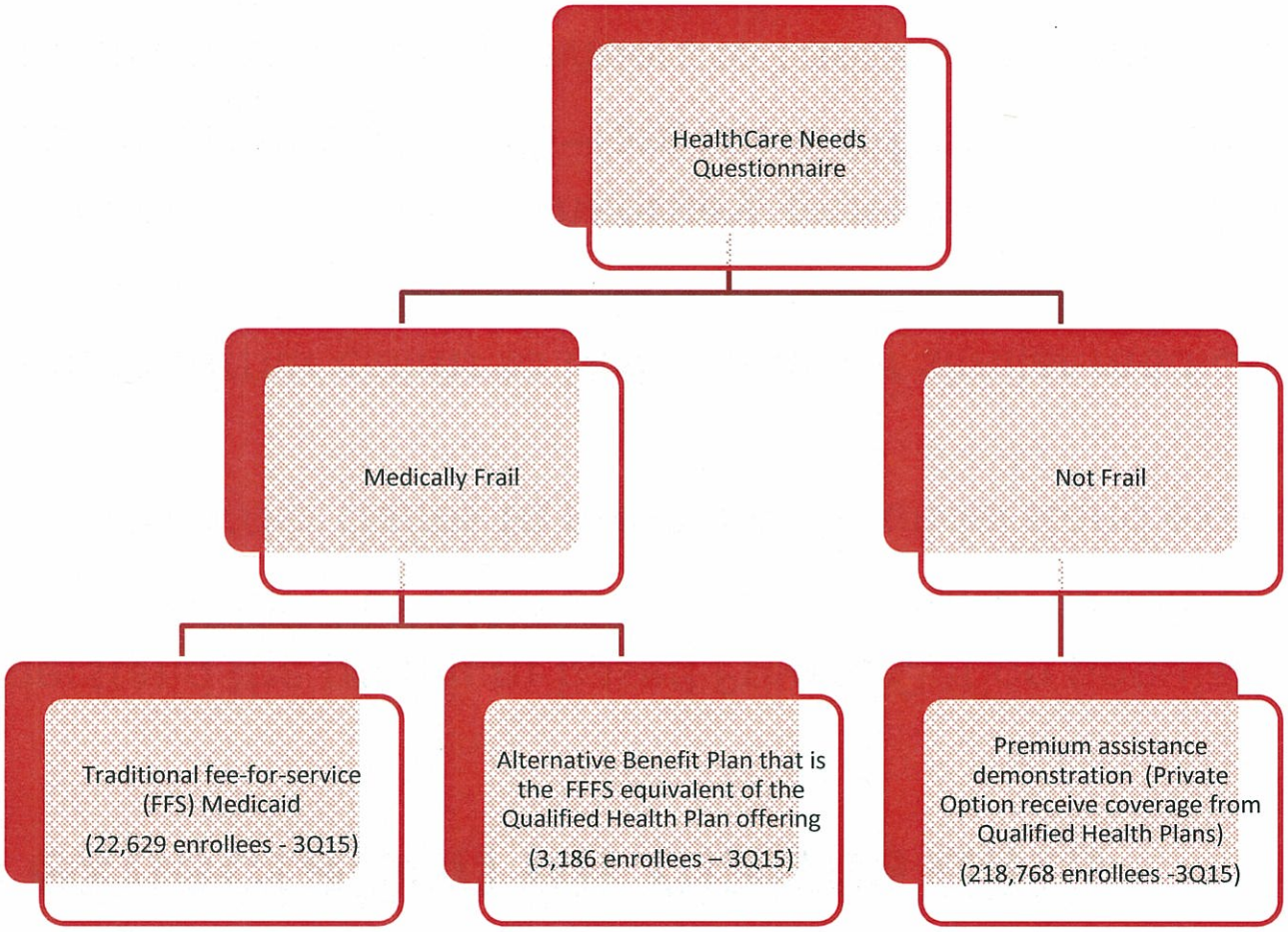
# TSG is in the process of clearing up these data issues

- Would not be helpful to present even high-level numbers today—wait for "hard" numbers at the next progress report
- Working actively with both carriers and DHS
- We anticipate that most of the data issues will simply require a different method of data analysis—that they are not real problems with data quality

# The expectation for claims data

- Understand the premium-based Private Option population: by age, county, level of claim experience, medical conditions
- Compare carrier claims to premiums to understand experience rate
- Compare carrier claims to DHS claims for similar medical conditions
- Frequency of claims by beneficiary, provider, county. Compare these for carriers and DHS—are there different patterns?
- Evaluate claims across providers to consider adverse trends in rates and utilization
- Evaluate specific questions such as use of nursing homes
- Create an on-going tool the BLR can use to consider policy questions

# Health Care Independence Program (243,615* see note below) newly eligible adults (3Q 15)



# Medicaid Program and Category Expenditures Previously Paid Under Traditional Medicaid but Now Paid Under Health Care Independence Program

**Programs eliminated in Traditional Medicaid but subsumed within HCIP**

- Family Planning ($1.6 M FY 15)
- Tuberculosis ($20,000 in dollars FY 15)
- Breast & Cervical Cancer ($4.3 M FY 15)
- AR Health Networks ($14.2 M FY 15)

**Categories formerly in Traditional Medicaid subsumed within HCIP**

- Medically Needy ($6.6 M FY 15)
- Aid to Aged, Blind, Disabled ($4.8 M FY 15)
- Pregnant Women ($19.6 M FY 15)

# Quarterly Traditional Medicaid and Private Option Population and Budget Expenditures Received From DHS for first three quarters of SFY 2015

| | | | |
|---|---|---|---|
| Traditional | 1,151,274,941 | 1,213,824,845 | 1,228,462,071 |
| Newly Eligible (Private Option) | 292,957,820 | 327,079,752 | 344,350,494 |
| Total | 1,444,232,761 | 1,540,904,598 | 1,572,812,569 |
| | | | |
| Traditional enrollment | 667,803 | 667,815 | 668,770 |
| Newly Eligible (PO) Enrollment | 216,232 | 228,983 | 243,615 |
| Total | 884,035 | 896,798 | 912,385 |
| | | | |
| PMPQ for Traditional | 1,724 | 1,818 | 1,837 |
| PMPQ for Newly Elig (PO) | 1,355 | 1,428 | 1,414 |
| Total | 1,634 | 1,718 | 1,724 |

Please note that recipients refers to MF individuals with paid claims; while eligibles to everyone who had MF designation

| | SFY 15 Q1 | SFY 15 Q2 | SFY 15 Q3 |
|---|---|---|---|
| Eligibles | 23,065 | 23,294 | 24,847 |
| Recipients | 22,827 | 23,292 | 24,823 |

# Private Option Medically Frail PMPM CY 14 Claims Incurred with Adjustment for Supplemental Payments

| 201410 | 201411 | 201412 | CY14 Claims Total | CY14 Supplemental Payment Estimate | Total |
|---|---|---|---|---|---|
| $ 508,779 | $ 370,890 | $ 332,884 | $ 4,999,005 | $ - | $ 4,999,005 |
| $ 3,241,027 | $ 2,806,953 | $ 3,187,885 | $ 26,343,316 | $ - | $ 26,343,316 |
| $ 83 | $ 88 | $ - | $ 745 | $ - | $ 745 |
| $ 2,115,162 | $ 1,783,161 | $ 1,633,712 | $ 27,008,040 | $ 18,891,276 | $ 45,899,316 |
| $ 18,455 | $ 24,320 | $ 14,645 | $ 189,528 | $ - | $ 189,528 |
| $ 5,293,937 | $ 4,302,218 | $ 4,460,334 | $ 54,901,964 | $ 2,012,599 | $ 56,914,563 |
| $ 4,040 | $ 3,884 | $ 10,137 | $ 137,394 | $ - | $ 137,394 |
| $ 4,712 | $ 4,560 | $ 456 | $ 12,008 | $ - | $ 12,008 |
| $ 1,842,586 | $ 1,475,735 | $ 1,574,686 | $ 20,202,323 | $ 14,541,026 | $ 34,743,349 |
| $ 40,588 | $ 33,938 | $ 43,628 | $ 380,749 | $ - | $ 380,749 |
| $ 46,196 | $ 33,369 | $ 36,375 | $ 428,600 | $ - | $ 428,600 |
| $ - | $ - | $ 212 | $ 1,982 | $ - | $ 1,982 |
| $ 13,115,564 | $ 10,839,116 | $ 11,294,954 | $ 134,605,654 | $ 35,444,901 | $ 170,050,554 |

| 201410 | 201411 | 201412 | CY14 Claims Total | CY14 Supplemental Estimate | Total |
|---|---|---|---|---|---|
| $ 22.11 | $ 15.96 | $ 14.45 | $ 19.54 | $ - | $ 19.54 |
| $ 140.86 | $ 120.78 | $ 138.42 | $ 102.98 | $ - | $ 102.98 |
| $ 0.00 | $ 0.00 | $ - | $ 0.00 | $ - | $ 0.00 |
| $ 91.93 | $ 76.73 | $ 70.94 | $ 105.57 | $ 73.85 | $ 179.42 |
| $ 0.80 | $ 1.05 | $ 0.64 | $ 0.74 | $ - | $ 0.74 |
| $ 230.08 | $ 185.13 | $ 193.67 | $ 214.61 | $ 7.87 | $ 222.48 |
| $ 0.18 | $ 0.17 | $ 0.44 | $ 0.54 | $ - | $ 0.54 |
| $ 0.20 | $ 0.20 | $ 0.02 | $ 0.05 | $ - | $ 0.05 |
| $ 80.08 | $ 63.50 | $ 68.37 | $ 78.97 | $ 56.84 | $ 135.81 |
| $ 1.76 | $ 1.46 | $ 1.89 | $ 1.49 | $ - | $ 1.49 |
| $ 2.01 | $ 1.44 | $ 1.58 | $ 1.68 | $ - | $ 1.68 |
| $ - | $ - | $ 0.01 | $ 0.01 | $ - | $ 0.01 |
| $ 570.01 | $ 466.41 | $ 490.43 | $ 526.17 | $ 138.55 | $ 664.72 |

# Top 1000 Arkansas Medicaid and Newly Eligible High Utilizers

- 990 Traditional Medicaid/10 Medically Frail
- Highest 100:
  - Hemophiliac
  - Newborns – NICU
  - Congenital Condition
- Highest 1000: Severe Mental Illness predominant
- 2/3 age 1 or less or b/w 22 and 64
- $132 Million Inpatient
  - Childrens Hospital $109,716,477.30
  - UAMS $8,051,344.00

| | Traditional Medicaid Eligibility Categories | Expansion Population – Medically Frail |
|---|---|---|
| Average | $322,742 | $55,081 |
| Total | $322,742,223 | $54,971,008 |
| High | $5,986,251 | $546,025 |
| Low | $219,225 | $29,939 |

# TSG Physician Survey Results: Payment Improvement Initiative

- 250 responses/approximately 10% response rate
- Caution: "Could be significant sampling bias"
- 67% were physicians
- 16.5% represented hospitals
- 94.3% provide care to Medicaid and vast majority have been prior to 2014
- Reaction to impact of Episodes of Care MIXED
- Over 80% familiar with PCMH, but less than 40% are PCMH providers
- TSG will continue to update survey when responses come in

# Provider Feedback

- Episodes of Care – Concerns that Principal Accountable Providers were being held accountable for spending that was not in their control
- Payment cuts – Significant Medicare payment cuts that may overshadow new revenue from private option
- Private option – Providers seeing more insured individuals, receiving more revenue due to additional insured residents; Drop in ER visits
- Uncompensated care – Fewer uninsured patients – hospitals providing less uncompensated care

# PCMH not connected to High Cost Case

- No comprehensive approach and plan for care coordination for the high cost, multiple services population ("80% of spend goes for 20% of the Medicaid population")
- While the PCMH model has elements of care coordination the model is essentially Primary Care focused and unconnected to the waiver(s) populations by design
- DHS, at the request of the Governor's office, did issue and RFI to assess capitated, full risk, managed care principles in these high cost long term care support areas (aged and disabled)
- TSG will be assessing such options and alternatives for TF review

# Episodes of Care
# Select Statistics

The following figures represent total activity to-date associated with the EOC program

- 3.12 million episodes (before exclusions)
- 2,083 distinct Principal Accountable Providers (PAPs) have been identified
- For Medicaid, 648 providers received gain share payments totaling $642,200, and 605 providers were deemed eligible for risk sharing totaling an amount of $710,034
- Approximate annual EOC spend, across all active episodes, Medicaid only – $179.3 million
- Annual savings for all Episodes between $9.6 MM and $28.2 MM
- $62.6M for all funds for the design, development, and implementation of the first 14 EOCs.

Sources: Arkansas Department of Health Services, "Selected facts relating to episode impact for Arkansas Medicaid, June 18, 2015 – updated July 8 with volume numbers"; Arkansas Center for Health Improvement, "Arkansas Health Care Payment Improvement Initiative: Progress Update", February 2015

# Episodes of Care: Early Findings

- The EOC Model was thoughtfully designed and constructed, with characteristics that focus on both medical cost & quality, with upside & downside impact for PAP.
- Measurable positive results, bending or flattening of the cost curve, have been observed.
- Sharing of information among PO Payers and DHS could generate greater value from EOCs to all parties
- Key concerns are the time and cost of EOC development, expansion, implementation and operational maintenance.

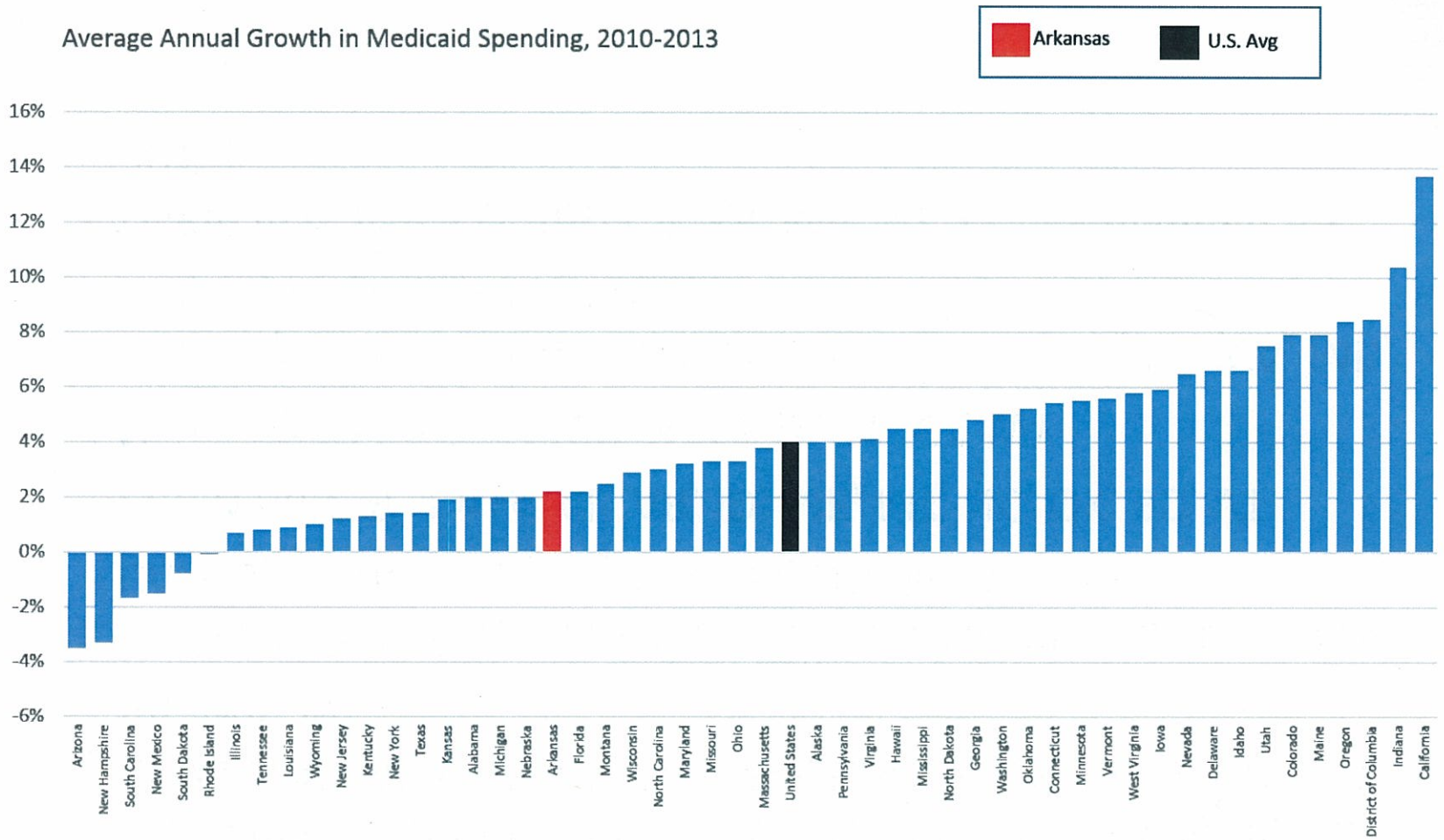
# Potential to simulate DRG Payment Model with claims data

- There is an opportunity to evaluate what a DRG payment model may yield compared to the current reimbursement method.
- DRGs may serve as placeholders until EOCs are established, or they can serve as a complimentary model where EOCs may not be necessary or optimal.
- Speed and reasonable cost of DRG implementation would allow for potential savings sooner.
- Universal acceptance by providers with Medicare and Commercial patients is also an advantage.

# State Medicaid Payment Reform Models: 2014

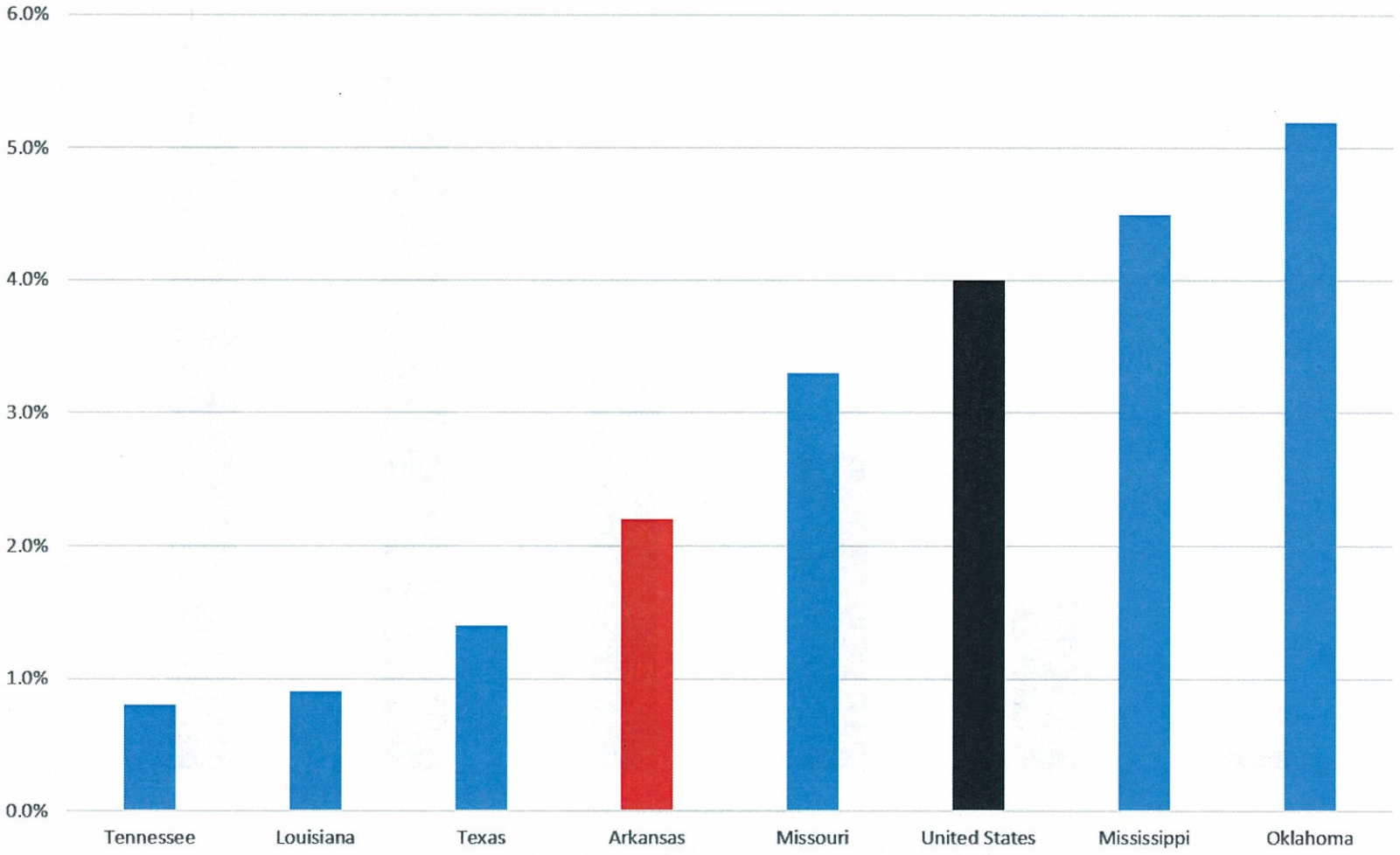
- Managed Care/Risk Based: 25 states: AZ, CA, DE, GA, HI, KS, KY, MI, MN, MO, NE, NV, NH, NM, NY, OH, OR, PA, SC, TN, UT, VA, WA, WI
- MCO and PCCM (Primary Care Case Management): 13 states: CA, CO, FL, IA, IL, IN, LA, MA, NV, ND, RI, WA, WV
- PCCM only: 9 states: AL, AR, ID, ME, MT, NC, OK, SD, VT
- No comprehensive MCO: 3 states: AL, CT, WY
- ACO in place: 8 states: CO, IA, IL, MN, OR, SC, UT, VT (CA, MD, ME, NJ, PA planned for 2015)
- DSRIP in place: 5 states: CA, KS, MA, NJ, TX (NY planned for 2015)

## Average Annual Growth in Medicaid Spending, 2010-2013



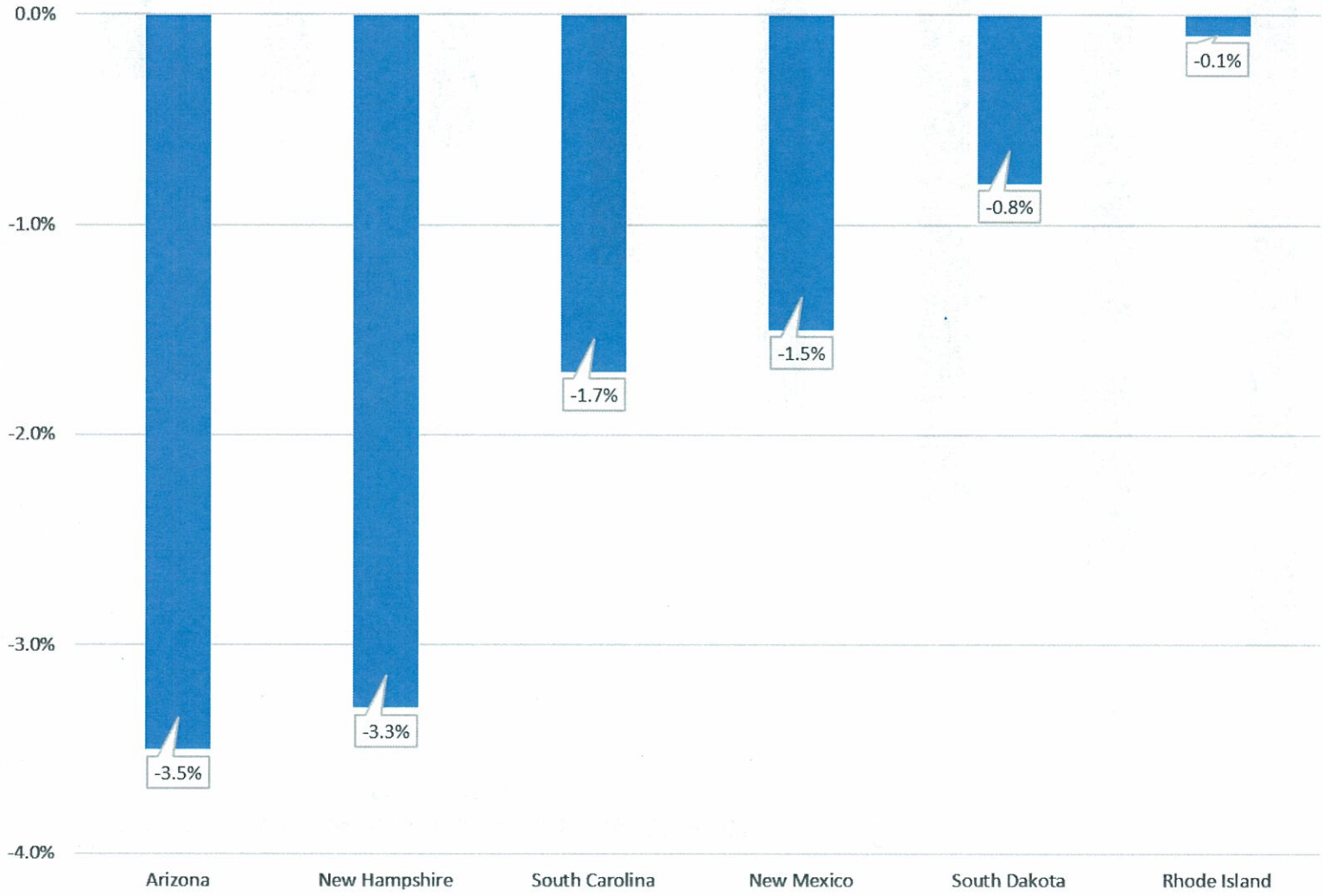

Source: Kaiser Family Foundation, Average Annual Growth in Medicaid Spending; http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending/

## Average Annual Growth in Medicaid Spending, 2010-2013
*Adjacent States*



## Average Annual Growth in Medicaid Spending, 2010-2013

*Very Low-Growth States*



# Status of InterRai Assessment Tools for DAAS, DDS, DBHS

- DHS chose InterRai program eligibility assessments instruments for HCBS waivers managed by DAAS, and DDS and RSPMI managed by DBHS in 2010/11. Project been underway at least 5 years.
- First project IT contractor CH Mack/MedCompass signed in 2011; terminated 2014.
- Second project IT contractor CoCentrix signed in 2014.
- Three phases of InterRai implementation:

❑1) Assessment;

❑2) Plans of Care;

❑3) Individual service plan budget based on tiered assessment level of care.

# Current Status of InterRai Universal Assessment Implementation

- DAAS: all three phases of functionality under development; assessment phase functionality being tested. Assessment functionality target date completion: 8/15; Phase Two and Three to follow acceptance of Phase One functionality.
- DDS: Assessment functionality completed 2/15; Phase Two Plan of Care delayed 3/15 - re-start date unknown; Phase Three tiered payments delayed to 2016.
- DBHS: "not actively" engaged in the project; to be reconsidered when DAAS and DDS work has been completed.
- Unclear involvement of the University of Michigan/InterRai organization with project management and contractor work: team member or not?
- Project phase closure is currently planned for 5/2016

# Medicaid Case Management in DAAS, DDS, and DBHS

- **Limited Case management services are available in the DAAS and DDS LTC systems. No case management services available in the DBHS regardless of severity of condition**

| Medicaid State Expenditures for Case Management | Expenditures Per Resident | Rank | Total Expenditures |
|---|---|---|---|
| Arkansas | $0.86 | 40 | $2,522,319 |
| Tennessee | 16.64 | 6 | 107,415,447 |
| Mississippi | 16.28 | 7 | 48,583,503 |
| Alabama | 13.36 | 12 | 64,415,780 |
| Oklahoma | 11.77 | 15 | 44,900,325 |
| Kansas | 10.48 | 17 | 30,246,141 |
| Missouri | 10.26 | 18 | 61,790,623 |
| Kentucky | 10.11 | 19 | 44,267,834 |
| Louisiana | 5.00 | 29 | 23,027,718 |
| USA | $8.53 | NA | NA |

Source: Medicaid Expenditures for Long term Services and Supports: FY 2012. CMS/Truven Health Analytics

# Behavioral Health Care Coordination

- Behavioral Health - limited care coordination service for up to 1,500 ("high utilizers") beneficiaries a year with a goal of reducing readmissions to inpatient psychiatric beds and Psychiatric Residential Facilities. (Children/adolescents)
- "Any willing provider" criteria for Residential Serious Persistent Mental Illness services has resulted in increased utilization but not necessarily coordinated care.
- No evidence PCMH model is targeted to address the psychiatric and social supports needs of people with severe and persistent mental illness who have multiple chronic care conditions (such as diabetes and obesity) and are high utilizers of inpatient psychiatric services.

# Nursing Facility Eligibility

- Nursing Home assessments are conducted by qualified staff from nursing homes
- Most often individual being assessed is admitted to NF
- Level of Care determined by rules and use of Form 703
- No mention of community based care as "priority" provided there are proper supports
- Medical criteria for level of care seen by medical staff at DHS as overly broad (TSG will be reviewing other state models)
- Medical necessity is determined by the DMS Office of Long Term Care, which also conducts required surveys of nursing homes
- Home and community waiver assessments conducted by DAAS nursing staff

# Human Development Center Expenditures FY 11 to FY 15 tied to Census

| HDC | FY 11 Expenditures | 6/30/11 Census | FY 12 Expenditures | 6/30/12 Census | FY 13 Expenditures | 6/30/13 Census | FY 14 Expenditures |
|---|---|---|---|---|---|---|---|
| Conway | $ 61,248,451 | 479 | $ 62,543,783 | 482 | $ 61,175,606 | 483 | $ 62,656,729 |
| Arkadelphia | $ 12,579,619 | 128 | $ 14,585,271 | 126 | $ 14,495,989 | 122 | $ 14,731,403 |
| Jonesboro | $ 10,401,648 | 113 | $ 11,658,527 | 111 | $ 12,405,612 | 113 | $ 12,679,736 |
| Booneville | $ 14,350,006 | 144 | $ 15,502,315 | 135 | $ 15,088,664 | 133 | $ 15,562,983 |
| Warren | $ 9,918,536 | 102 | $ 12,501,899 | 97 | $ 12,498,123 | 92 | $ 12,715,846 |
| Total Expenditures/ Census | $ 108,498,260 | 966 | $ 116,791,795 | 951 | $ 115,663,994 | 943 | $ 118,346,697 |

* Alexander HDC was decertified at the end of FY11.

**FY15 Expenditures are not yet available due to the 45 day rule which allows expenditures that meet the criteria to be posted to FY15 until around August 1 that time.

# Health Independence Account

- Of the 45,839 cards issued, 10,806 have been activated
- Number of transactions over the last several months remains relatively steady around 4,000 transactions per month
- Number of contributions has fluctuated some, but appears to have stabilized around 2,500 per month
- Call center activity has shown a consistent downward trend

| Month (all 2015) | Successful Transaction Count | Successful Transaction Amount | Contributions Count | Contribution Total |
|---|---|---|---|---|
| January | 3907 | $ 32,505.26 | 326 | $ 3,613.00 |
| February | 4844 | $ 42,432.00 | 3,114 | $ 41,163.81 |
| March | 4284 | $ 38,076.00 | 2,897 | $ 39,355.75 |
| April | 3959 | $ 34,090.00 | 2,765 | $ 37,187.39 |
| May | 3749 | $ 34,357.00 | 2,564 | $ 34,041.65 |
| June | 4112 | $ 37,308.00 | 2,480 | $ 33,229.10 |
| | | | | |
| Total (year to date) | 24,855 | $ 218,768.26 | 14,146 | $ 188,590.70 |

# Issues Involving Payment Integrity

- OMIG review early 2015 finding $500,000 paid in premiums for individuals who were deceased
- No automation and integration of systems from Department of Health (DOH) on vital records to DHS
- DOH building system that will allow real-time data exchange of death data but not currently in DHS EEF Plan
- 300 individuals where premiums were paid when after reaching age 65
- DHS implemented Plan of Action in response to OMIG review
- Health Care Independence Account had 4000 cards returned since beginning of this year due to bad addresses
- No system in effect to determine if individual on Private Option is incarcerated - but outreach efforts occurring to sign up individuals who are incarcerated "upon release."

# SFY 2015 Newly Eligible Premium and Cost Sharing Payments and Total Recoupments from Carriers

| SFY 2015 Newly Eligible Premium & Cost Sharing Payments | | | | | | | |
|---|---|---|---|---|---|---|---|
| SFY 2015 | | | | | Net Totals | | |
| Month | PO Premium Payment | PO Premium Recoupment | PS Cost Sharing Payment | PS Premium Recoupment | PO Premium Payment | PS Cost Sharing Payment | Total Recoupment From Carriers |
| July | 52,091,184.63 | 0.00 | 19,962,782.86 | 0.00 | 52,091,184.63 | 19,962,782.86 | |
| August | 56,154,032.15 | (1,460,474.60) | 21,545,980.34 | (609,189.88) | 54,693,557.55 | 20,936,790.46 | |
| September | 58,197,543.07 | 0.00 | 22,335,424.97 | 0.00 | 58,197,543.07 | 22,335,424.97 | |
| October | 60,458,127.61 | (359,582.03) | 23,195,253.72 | (129,451.97) | 60,098,545.58 | 23,065,801.75 | |
| November | 64,374,376.68 | (134,041.99) | 24,479,654.62 | (50,611.18) | 64,240,334.69 | 24,429,043.44 | |
| December | 65,028,650.52 | (1,513,726.19) | 24,755,151.61 | (498,814.06) | 63,514,924.33 | 24,256,337.55 | |
| January | 68,503,807.95 | (146,234.86) | 25,508,151.10 | (45,714.97) | 68,357,573.09 | 25,462,436.13 | |
| February | 70,489,194.23 | (268,390.63) | 26,248,599.58 | (99,976.36) | 70,220,803.60 | 26,148,623.22 | |
| March | 72,250,018.41 | (1,730,583.95) | 26,896,652.57 | (667,834.16) | 70,519,434.46 | 26,228,818.41 | |
| April | 82,026,788.12 | (9,686,442.34) | 30,549,069.67 | (3,662,625.02) | 72,340,345.78 | 26,886,444.65 | |
| May | 77,779,352.57 | 0.00 | 29,021,788.79 | 0.00 | 77,779,352.57 | 29,021,788.79 | |
| June | 76,553,986.59 | (1,704,545.57) | 28,495,528.33 | (657,785.92) | 74,849,441.02 | 27,837,742.41 | |
| Total | 803,907,062.53 | (17,004,022.16) | 302,994,038.16 | (6,422,003.52) | 786,903,040.37 | 296,572,034.64 | (23,426,025.68) |

Bureau of Legislative Research

# Arkansas Health Care Reform Task Force: Pharmacy Observations

TSG Update Report #2

July 15, 2015

Rory Rickert – TSG Senior Consultant

# Pharmacy

- Prescription limits
  - Prescription medications relatively inexpensive intervention
  - Benefits seen in reduced medical spend
  - Improved adherence – modest drug spend increase
    - Difficult to analyze
      - Claims beyond the limit not in the data set
  - Consider exempting maintenance medications
    - In line with value based benefits
    - May need to modify the limits and the "extension of benefits"

# Pharmacy

- PDL expansion
  - Strict reliance on evidence based approach is limiting
  - Appears in a State rule—consider modifying
  - If no differential evidence—cost difference sufficient for preferred PDL status
    - Expand classes covered
    - Improve supplemental rebate potential
- Consider multistate rebate pools
  - Size and control key factors
    - Good on control
    - Weak on size
      - Approximately 3mm lives minimum to stand alone

# Pharmacy

- Redundant call centers
  - UAMS College of Pharmacy
    - Non-PDL request
    - Select other clinical questions
  - Pharmacy Department at the State
    - Catchall
  - Magellan
    - Administrative
  - Consider consolidating
    - Reduce duplicate administrative costs
    - Improve efficiency and convenience

# Pharmacy

- Copay differentials
  - Absolute differences small
  - Differences should align with PDL tiers
    - FFS and PO

# Pharmacy

- Opiates
  - Overuse in US and Arkansas
  - 5mm claims in FFS pharmacy
    - 350 k +claims for opiates
    - 28 k utilizers
    - 70 locked to one pharmacy
  - Consider allowing lock in to one prescriber
    - Decrease utilization of opiates and costs
  - Statewide controlled drug tracking data base
    - Viewed by prescribers and dispensers
  - Consider granting access to clinicians at DHA
    - Improve retrospective DUR and clinical outcomes

# Pharmacy

- Vendor oversight
  - Outside PMO function common in IT
    - Magellan not an IT company
  - Vendor selection and implementation complete
  - Steady state
    - Likely to operate fine without added cost of oversight

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# Arkansas Health Care Reform Task Force: Contracts Observations

TSG Update Report #2

July 15, 2015

# Observations on Top 25 Contracts

- TSG reviewed the top 25 contracts to see how DHS procured these vendors, how the spend changes from year to year, what the deliverables are, what the performance indicators are, and what the remedies for unacceptable performance are.
- Standard clauses which are very favorable to the State include cancellation provisions, dispute resolution, subcontractor control, indemnification, and payment of legal fees.
- All contracts have the requirement for the vendor to submit and implement a corrective action plan for any issues within the scope of the contract.
- All contracts have the option to withhold or reduce payment. Most contracts lack specificity around the withholding or reducing of payments.

# Observations on Top 25 Contracts cont.

- DHS consistently manages vendors on a year-by-year basis over the course of the seven years a procurement can cover.
- DHS has some strong examples of contracts with specific deliverables and consequences for missing deliverables.
- DHS has some great examples of making vendors live up to the promises they made in their proposals.
- Unfortunately, DHS also has many examples of performance indicators that are little more than a statement of work (or scope statement) and do not demand a quantitative, quality oriented standard for how the work is to be delivered.
- Of the 25 contracts reviewed, 18 were a result of a competitive bid, four were sole source and three were intergovernmental agency agreements. Given the dollar amount of these contracts, it is surprising to see the sole source contracts to HP, McKinsey, Cognosante, and Datapath.

# Key Contracts

- EEF Project
  - IBM recommitted to the continued investment in the Curam product
  - PMO started 7/1/15 and is preparing a Gantt chart with dependencies
  - Federal APD updated with $188 mil total project funding
  - Procurement for Traditional Medicaid work moving forward with a July 2016 start date for new contracts
  - Extensions to two sole source contracts required to get from current end dates to the July 2016 start date

# Key Contracts cont.

- McKinsey Contract
  - McKinsey outlined a deliverable framework for their work this fiscal year
  - TSG responded with a more detailed document with 53 separate deliverables
  - Recommend clarity around what happens if DHS does not move forward on all 10 episodes of care
  - Recommend more clarity, or even competitive procurement on potential RFP work and the $1.5 mil "as determined by DHS" bucket of money
  - McKinsey and DHS reviewing TSG recommendations and McKinsey seems willing to accept recommendation - negotiations continue