HealthFocus

Government Healthcare Solutions News

CONDUENT

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THE INDUSTRY

The Impact of Medicaid Managed Care Final Regulation

Released on April 25, 2016, the Medicaid and CHIP Managed Care Final Rule provided the first major update to Medicaid and CHIP managed care regulation in more than a decade.
Page 8

OUR BUSINESS

Network Adequacy Monitoring Improves Access to Care

This past April, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revised and strengthened existing Medicaid managed care rules.
Page 18

YOUR NEWS

Mississippi Eligibility Modernization Project

In August 2016, Mississippi moved a step closer to a fully integrated eligibility system with the completion of its modernization project.
Page 24

HealthFocus

Government Healthcare Solutions News

Volume 9, Issue 1
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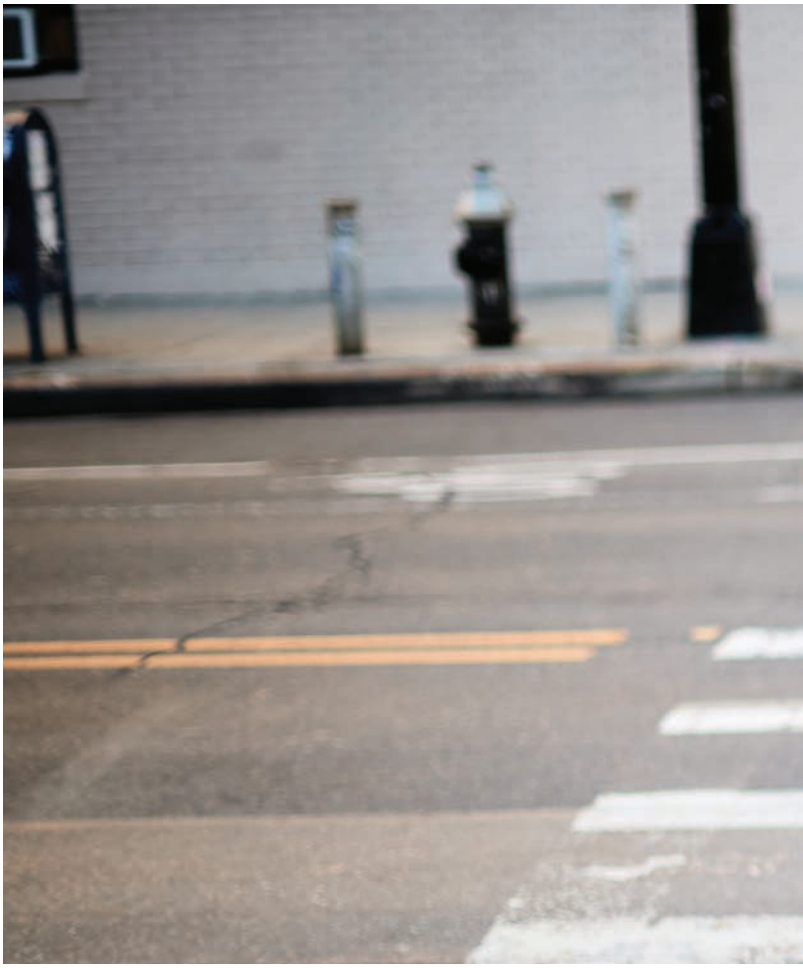
THE INDUSTRY

How Can Technology Support Collective Impact and Improve Outcomes?



By Sophia Blachman-Biatch

"Collective impact" has been gaining more traction among government healthcare and other assistance programs over the past few years.

If you're not familiar with the concept, it began in the world of nonprofit organizations. Traditionally, a nonprofit identifies an issue affecting a community, such as hunger, teen pregnancy or low graduation rates, and rallies resources to address it. The organization sets goals and performance measures based on how it affects its focal issue. As multiple nonprofits tackle multiple issues independently, overall quality of life in the community will improve.

What is Collective Impact?

The idea behind collective impact is that complex challenges can be addressed more effectively when silos between assistance organizations are removed and they can work together collectively on improving a community. The approach inverts the traditional "isolated impact" method of assistance, starting instead by setting goals of improving a community and working backward to create a coalition of groups across different areas of expertise that can create and coordinate integrated strategies to achieve that goal.[1]

For example, the community goal could be to increase graduation rates by 20 percent or halve teen pregnancy rates. In collective impact, a coalition of nonprofits, government agencies, schools, businesses, philanthropists, faith communities, hospitals, neighborhood organizations, community leaders and more would form to attack the problem using their areas of focus. Each group's success is measured not by the outcomes of their particular clients, but by how much their actions affect the collective goal.

How Does It Affect Healthcare?

What does collective impact mean in the healthcare world? The Affordable Care Act laid the groundwork for substantial improvements in population health by broadening the focus of health systems and hospitals beyond care delivery. Improving population health today means looking at complex and interdependent systems that affect health, including social and economic factors, health behaviors and the physical environment. To address them, providers must align efforts with local health departments and community groups, gather feedback from communities and experts, complete requisite needs assessments and implement programs to promote community health.

The Role of Technology

When John Kania and Mark Kramer formally introduced collective impact in the *Stanford Social Innovation Review*,[2] they outlined five requirements for effective collective impact:

- A backbone organization
- A common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communication

At each level, health departments, hospitals, health systems and even managed care organizations are using emerging technologies to enact successful collective impact approaches to address long-term, large-scale problems. Why? Technology can establish a centralized and dynamic measurement system and communication tool for communities to align efforts to achieve common goals through transparent and accountable means. When the organizations involved in a collective impact initiative are more aligned and integrated through technology, they can be more effective in achieving the collective impact goal.

In this article, we'll examine the growing importance of technology in a collective impact approach focused on population health improvement. It draws best practices and lessons learned from a collective impact initiative in Orange County, California.

Supporting the Backbone Organization

The backbone organization is the focal point for bringing about collective impact. It acts as a "convener"; it brings together the other support groups that can improve outcomes in the community. The backbone organization also connects these groups with the resources and infrastructure needed to bring about improvements as well as helps shape policies that will keep all groups aligned toward the same goal. As the central player in the initiative, the backbone organization can accelerate adoption and implementation of a governance plan, mobilize funding and build public will toward the collective goal.

At an operational level, the backbone organization supports logistic administration and community and stakeholder management. Technology primarily adds value here with tools for project and time management, operations, organization and communications, upon which the backbone can rely to keep the collective impact initiative running smoothly.

In our example, the Orange County Health Care Agency (OCHCA) supports a network of more than 80 private and public organizations, including UC Irvine, Hoag and Kaiser Permanente, among others. These multi-sector groups work together on Orange County's Healthier Together initiative and are led by the Orange County Health Improvement Partnership (HIP). The agency coordinates at a high level through various assessments, planning processes and OCHealthierTogether.org, which is a centralized data and community resource platform that they help fund.

Beyond optimizing internal coordination and publishing results, Orange County's Healthier Together website provides justification of collective impact maturity to help all partners win competitive grants to further the common agenda. For example, a coalition within the partnership won a CDC Partnerships to Improve Community Health grant of over $1.3 million dollars to further their work with Latinos, Asians and Pacific Islanders who suffer from high rates of death due to diabetes and other chronic diseases.

Defining a Common Agenda

To develop a common agenda, the organizations involved in collective impact must meet and define goals through mutual discussion. This involves assessing progress on the collective goal to date, setting priorities and preparing for challenges, as well as clarifying roles, responsibilities and a framework for action. The agenda should include broad and high-level priorities so each group can contribute within their area of expertise. The group should also lay out a framework for action for priority areas with goals, objectives and process and outcome measures.

Technology's role in the common agenda is as a contextualizer: it helps centralize goals, objectives and initiatives alongside resources, data and analytics to provide insight. Technology is also the connector, conferencing in experts from outside the local area so the group's knowledge resources are not limited by geography or time zone.

Orange County's HIP unites behind the mission to align public and private resources to advance health for all communities in the county. Using the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning tool, the group prioritized four areas: Infant and Child Health, Older Adult Health, Obesity and Diabetes and Behavioral Health. Each has its own goals, strategy, data and activities on OCHealthierTogether.org. Within each area, planning groups convene to develop goals and strategies and execute initiatives.

Establishing a Single Source of Truth

The key to collective impact is using a shared measurement system to link all of the organizations' performance to achieving the common goal. It acts as the central tracker for partners to agree on key objectives and goals for specific health, quality of life and process indicators. Monitoring progress around the common agenda through measurements and ongoing reporting provides a "single source of truth" for the initiative by which all groups can be measured.

Today, technology enables coalitions to use a centralized online system that provides all appropriate users access to the most current data (including trend charts), measurement definitions and comparison and target values. Partners can access all the data and upload their own custom indicators to increase transparency and benefit from feedback. As the number of relevant data sources continues to grow, collaborators increasingly rely on data scientists, epidemiologists and/or a user-friendly platform to parse data and provide access to presentation-ready indicators.

In developing the Healthier Together website (in partnership with Conduent Community Health Solutions), Orange County determined more than 300 health and quality of life indicators from over 40 national and local sources to serve as outcome measures. For each priority area, the site contextualizes progress on outcomes by including goals, initiatives and community events. Demographic data is available for download. New indicators and comparisons are added as needed. Partners use the charts and dashboards on their own websites, reports and presentations.

"Up until we launched OCHealthierTogether.org, we didn't have one central place focused on community health in Orange County. Information was distributed through many different published reports," said Jane Chai, MPH, at the Orange County Health Care Agency. "Now, all our community partners can look at the same indicators with the same definition, over the same time frame, so we can all be aligned in our efforts."

Mutually Reinforcing Activities

Mutually reinforcing activities are evidence-based interventions chosen to align strategically with the common agenda. To best achieve the collective impact goals, they should be supported by a diverse set of partner organizations, such as city planners, researchers, teachers, students, hospitals, clinics. It's important that each one shares its progress and findings on an ongoing basis.

Learn about more communities using technology for their collective impact approach

San Francisco, Calif.
SFHIP.org

DuPage County, Ill.
ImpactDuPage.org

District of Columbia
DCHealthMatters.org

Delaware and Blackford Counties, Ind.
HealthyCommunityAlliance.org

Greater Hampton Roads, Va.
GHRConnects.org

Technology can improve the efficacy of these programs by augmenting participant recruitment. For example, they can increase engagement through social media and mobile devices. In addition, a centralized community website can encourage accountability, coordination, transparency and ongoing assessment.

Orange County organizes a constant stream of community activities led by the coalition's work groups. One work group developed the 2016 Orange County Older Adult Profile on OCHealthierTogether.org, highlighting key health, social and economic indicators in this population. Another work group targeting obesity analyzed geographic disparities in childhood and adult obesity rates, hospitalization rates, park access, food access and childhood poverty rates. It uncovered four cities with the highest need: Santa Ana, Anaheim, La Habra and Buena Park. With funding from Kaiser Permanente, OCHCA awarded grants to Buena Park, La Habra, and Santa Ana to implement place-based strategies that address childhood obesity and provided trainings on community engagement and collective impact.

Continuous Communication

As in any large-scale project, continuous communication is vital to collective impact's success. It builds transparency, accountability and trust and maintains a common vocabulary between the partner organizations. The timing is important; the initiative is more successful when the groups can meet monthly or even weekly. Communicating effectively relies on publicly sharing meeting logistics and content. This not only keeps the groups accountable and in the loop; it also garners community feedback.

Technology has communication tools for each step: recruitment, tracking and sharing progress, planning and cementing partnerships and building excitement. Diverse stakeholders find that a shared system helps make their work transparent to other stakeholders and strengthens ongoing communications and programs.

Within OCHealthierTogether.org's Infant and Child Health, Older Adult Health, Obesity and Diabetes and Behavioral Health sections, subject-specific planning groups post progress on initiatives, meeting information, communicate goals and priorities and invite public participation. The coalition's backbone organization collects progress and updates from the partner organizations and develops and shares newsletters regularly. The site communicates local resources available to patients and local activities to drive change. Sessions devoted to learning to use the data platform and public comment provide ongoing touchpoints.

Conclusion

The combined efforts of people and organizations can create lasting change. Using technological innovations, we can connect and support one another at greater distances. Technology increases transparency, efficiency, drives accountability and allows us to communicate impact, all of which are driving forces to build more support and resources. ●

Conduent Healthy Communities Institue, a leading community health analytics platform, has worked for over a decade to help public health departments, hospitals, community coalitions and non-profits achieve collective impact.

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THE INDUSTRY

Value-Based Payment: The Role of Medicaid Programs

By Dawn Weimar, RN

In this time of political change and shift toward managed care, one thing seems certain: value-based payment for healthcare will continue as a national priority to align healthcare payment with quality.

The Medicare Access and CHIP Reauthorization Act (MACRA), for example, is heralded as bipartisan legislation that links payment to the quality of physician care. MACRA includes an all-payer variant, encouraging participation not just from the Medicare payers and providers but also from Medicaid and commercial payers and providers.

What role will your Medicaid program play in this journey to emphasize more value in healthcare? Some states are delegating the measurement of outcomes to managed care plans (MCPs), but there are limitations to this approach:

- How do state Medicaid programs verify the accuracy of reported outcomes?
- Can you compare MCPs' or hospitals' performance with each other or to a benchmark?
- How do you measure improvement over time?
- How can you link hospital or MCP performance to payment?

Most large MCPs have measured outcomes for decades and have the resources to do so credibly. However, this is not true of all MCPs. Even if there is agreement on a common set of measures, healthcare outcomes quantified by individual MCPs may not be comparable for many reasons. The programmer/analyst must understand the specific protocol for the measurement and be technically competent to produce the desired measure. (Healthcare Effectiveness Data and Information Set [HEDIS] measures

often require programming and data analysis comparable to a mini-study with multiple analytical steps.) Many plans, highly focused on the daily routines of networks and claims adjudication, may have varying degrees of aptitude for the complexities of data maintenance, data cleanup and audit of the measurement, as well as varying levels of interpretation and statistical appropriateness. Finally, casemix adjustment of healthcare outcomes is critical for comparative analysis as the mix of patients can vary considerably by type of hospital and between MCPs. Also, many MCPs may not have access to casemix adjustment tools or to the statewide data needed to establish benchmarks and perform comparative analysis. Outcomes that are not casemix-adjusted are simply not sufficient as a basis for value-based payment.

Furthermore, an independent survey of Medicaid managed care plans in California found considerable variation in which outcomes are measured. In fact, only 25 percent of plans measure readmissions.[1] This is unfortunate considering readmission measurement is a critical cornerstone of healthcare performance measurement.[2]

Leaders in the quality movement have reacted to the proliferation of quality measures by advising that payers "…align with other payers on a smaller required set of high-impact and outcome-oriented measures."[3] The question is how best to drive true value-based care grounded in both quality improvement and cost savings given limited resources for both managed care plans and Medicaid programs.

Several states have already achieved double-digit decreases in inpatient complications and readmissions and saved hundreds of millions of dollars using a state-driven approach. Maryland,[4] Texas,[5] Illinois[6] and Minnesota[7] have all published improved healthcare outcomes. These range from Maryland's 26.3 percent reduction in potentially preventable complications between 2013 and 2014 to a 25 percent reduction in potentially preventable readmissions for the Texas Medicaid STAR program between 2012 and 2015. Others, such as New York Medicaid, have transparently published healthcare outcomes by hospital to encourage value-based care.[8]

How can state Medicaid programs assist in moving value-based payment forward? One strategy that has proven successful in our experience is a state-orchestrated approach incorporating claims and encounter data.[9] When a state makes a reasonable investment of time and resources as a purchaser, it realizes benefits beyond self-reported measurement. In this scenario, the state controls both the methodology and the payment, ensuring that each measure is accurate and calculated similarly for each plan or hospital. This ensures that accurate comparisons of casemix-adjusted outcomes can occur at any level: MCP, hospital or region, for example. In addition, year-over-year monitoring of outcomes can be compared to a benchmark and tied directly to payment, providing a financial incentive for quality improvement.

Finally, a state is empowered to establish more pertinent healthcare outcome measures specific to a Medicaid population. Medicare's focus on only three conditions for readmission — heart failure, heart attack and pneumonia — does not suit a Medicaid population.

Our Payment Method Development team has found that providers welcome a fair and transparent process that provides them with quality, actionable healthcare outcomes measures — information that can pinpoint areas of care that need refinement to achieve the triple aim of improving population health, reducing per capita healthcare costs and improving the patient experience.[10] A state Medicaid-sponsored quality healthcare outcomes initiative that informs hospitals and managed care plans of their performance compared to a benchmark will encourage improved health for Medicaid beneficiaries and ensure program dollars are spent wisely. ●

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THE INDUSTRY

The Impact of Medicaid Managed Care Final Regulation

Released on April 25, 2016, the Medicaid and CHIP Managed Care Final Rule provided the first major update to Medicaid and CHIP managed care regulation in more than a decade.

Since that time, CMS has released and will continue to release, sub-regulatory guidance which will further clarify and provide guidance regarding the final rule.

Key provisions of the rule align Medicaid managed care with Medicare Advantage and qualified health plan programs offered through exchanges under the Affordable Care Act (ACA). The regulation also strengthens the actuarial soundness of managed Medicaid programs while ensuring protection of beneficiaries. New provisions will primarily be implemented over a three-year period, starting with a rating period for contracts beginning on or after July 1, 2017.

Let's look at some of the specifics contained within the final rule and their potential impact over time. It should be kept in mind that impacts related to potential ACA repeal and replacement or reform of the Medicaid program (such as block granting, a private option for expansion populations, etc.) could impact the following provisions; but for now, they remain in place.

Alignment with Other Coverage Programs

Many of the provisions of the final rule bring the program into close(r) alignment with Medicare, Exchange and Commercial managed care programs. Here are a few examples.

Many of the provisions of the final rule bring the program into close(r) alignment with Medicare, Exchange and Commercial managed care programs.

Phase-out of Supplemental Payments

Beginning with contracts effective on or after July 1, 2017

5 years

Long-term care facilities

Pass-through payments will be phased out over a five-year period without annual requirements.

5 years

Physicians

Pass-through payments will be phased out over a five-year period without annual requirements.

10 years

Hospitals

Pass-through payments must be phased out within 10 years at a rate 10 percent per year.

Managed Medicaid plans' Medical Loss Ratio (MLR), the portion of premium revenues spent on clinical services and quality improvement, has been set at 85 percent — in line with Medicare and other programs. Currently, the actual MLR for individual plans still varies considerably within and between states. The rule should prompt plans to consider adjusting their spend on medical care versus administrative expenses to align with the national standard.

Plans must place rating information on member portals to help consumers compare managed care organizations (MCOs) and make informed decisions about selecting coverage. Plans need to use multiple communication methods, "including mail, email and website posting for the dissemination of required information while maintaining the ability of consumers to obtain these materials in paper form upon request and at no cost."[1]

Managed care plans must include provider directories and drug formularies on their websites. These directories must be updated frequently; states will monitor the plans to ensure that enrollees have up-to-date and accurate information regarding providers. Provider directory information must include provider group and hospital affiliations, physical accessibilities and more.

Although providers participating in Medicaid Managed Care don't have to participate in the Medicaid fee-for-service program, the standard does require all managed care program providers to be screened and enrolled by the state Medicaid Program.

Provider Pass-Through Payments

Traditionally, CMS has not allowed states to set up contracting mechanisms for pass-through payments to providers. That concept remains in the final rule. The rule requires the phase-out of supplemental payments to hospitals, physicians and nursing facilities. Beginning with contracts effective on or after July 1, 2017, pass-through payments for hospitals must be phased out within 10 years at a rate of 10 percent per year. Pass-through payments for physicians and long-term care facilities will be phased out over a five-year period without annual requirements.

The final rule does contain exceptions which permit states to direct managed care plans' expenditures. They include:

1. Value-based payment models
2. Delivery reform methodologies, such as accountable care organizations or medical homes
3. Performance improvement initiatives (e.g., related to outcomes or quality)

States could try to closely mimic provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) to avoid Medicaid and Medicare providers effectively having to run two different practices. However, there will likely continue to be significant variation between states in implementing these exceptions.

Program Integrity

As stated by CMS "The final rule strengthens the fiscal transparency and integrity in Medicaid and CHIP managed care."[2] Besides some of the provisions mentioned above, the final rule expands managed care plan responsibilities in program integrity efforts and adds requirements related to encounter data submissions.

The final rule outlines requirements for both the types of data to be used for rate-setting as well as the required documentation to support the rate certification, such as "trend factors, adjustments and the development of non-benefit costs."[2] These requirements should enable to review and approve capitation rates more effectively. The final rule also allows states to change the certified capitation rate by 1.5 percent without CMS's review and approval.

The final rule lays out procedures for internal monitoring of plans, as well as mandatory reporting for potential fraud, waste or abuse. Provider sanctions (including payment stoppage) will be required at the direction of the state.

The requirements for submitting valid encounter data are also strengthened both from the plans to the states and on to CMS. CMS will enforce the submission of "complete, timely and accurate encounter data submissions"[2] by withholding federal financial participation where these criteria are not met.

These and other program integrity activities are designed to provide more effective management of the managed care program and avoid wasting program resources.

Long-Term Services and Support

To incent states to enroll additional Managed Long Term Services and Supports (MLTSS) members in managed care, the final rule includes provisions which create a positive environment for the delivery of MLTSS services. CMS has strengthened approaches to MLTSS programs and beneficiary protections while allowing states flexibility in program design and administration. This is achieved through provisions requiring a state planning process, a centralized independent beneficiary support system supporting choice counseling and other services, person-centered processes and more.

To support the many MLTSS requirements, plans will need to be able to conduct member assessments, institute plans of care, develop budgets, do time-and-attendance monitoring and implement care coordination and care management activities. The goal in managing the Medicaid LTSS population is to provide care within the community rather than in an acute care facility.

The goal in managing the Medicaid LTSS population is to provide care within the community rather than in an acute care facility.

It should be noted that the 21st Century Cures Act requires Electronic Visit Verification with phased-in dates for personal care and home health services provided under Medicaid, including fee-for-service and Medicaid managed care plans.

Network Capacity and Adequacy

The capacity of managed care plans to provide adequate provider networks to deliver care to members has long been a concern for states, members and plans. The final rule looks to ensure that provider networks have the capacity to allow sufficient access to care. States must contract with MCOs to develop and enforce adequacy standards. These would include minimal time and distance standards for members to access care as well as openness to accepting new patients.

CMS plans to release guidance early in "either January or February 2017" which will affect "new contracts between states and plans [that] go into effect on July 1, 2018."[3] The final rule establishes network adequacy standards in Medicaid and CHIP managed care for key types of providers while leaving states flexibility to set the actual standards.

Managed Care Quality Strategies

The final rule addresses many quality standards which must be incorporated into a Medicaid managed care delivery model. They include:

- **Quality Assessment and Performance Improvement Programs.** States must require contracted MCOs to establish and implement an ongoing comprehensive quality assessment and performance improvement program. These programs must include "mechanisms to detect both underutilization and overutilization of services and the quality and appropriateness of care furnished to enrollees with special health care needs."[4]

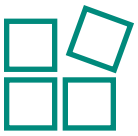
- **Medicaid Managed Care Quality Rating System.** The final rule requires states "to adopt a Medicaid managed care quality rating system (QRS)…which will align with the QRS developed for the Qualified Health Plans on the Federal Health Insurance Marketplace, or an alternative state-developed system that is reviewed and approved by CMS."[4]

Other quality standards include issues of network adequacy, those that explicitly address the needs of MLTSS members, External Quality Review requirements and others. The goal is to "enhance transparency in Medicaid and CHIP managed care, supports states in contracting with health plans that offer higher-value care, improve consumer and stakeholder engagement and, where feasible, align quality measurement and improvement in Medicaid and CHIP managed care with other systems of care."[5]

Medicaid Forecast

Expected impact of the expansion of Medicaid eligibility

Increase in Medicaid's importance to the U.S. healthcare system
Greater attention to be put on its fiscal sustainability



Increased consolidation among plans
Enabling efficiencies and cost savings

Growth in private managed care
Strong competition among plans can result in an emphasis on controlling costs and driving superior results

Beneficiaries' needs more frequent and expensive
More services needed for seniors, the disabled, and those needing long-term services and supports

Comingling of Medicare and Medicaid enrollees
More pressing need to find a solution for those caught between Medicaid and subsidized individual coverage

Source: Gottlieb, Ari. *The Steadying State of Medicaid in the United States.* Rep. PwC, Sept. 2016. Web. 10 Jan. 2017. www.pwc.com/us/en/health-industries/publications/assets/the-steadying-state-of-medicaid-in-the-united-states.

Oversight and Monitoring Requirements

The final rule specifies new oversight and monitoring requirements that all managed care programs serving state Medicaid members must follow. They cover areas including:

- Plan administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services
- Finance, including medical loss ratio reporting

In addition, plans must provide an annual report that must include information on financial performance, accessibility of services, analysis of encounter data, grievances and appeals and quality improvement.

Expected Impact

According to a recent report from PwC,[6] Medicaid has moved into a steady market phase with overall enrollment nearing a ceiling. States are reaching critical mass with almost three in four beneficiaries in private health plans. The forecast calls for:

- Medicaid becoming more important to the overall U.S. healthcare financing and delivery system. Greater attention will be placed on contracting practices, plan and provider payments and the program's fiscal sustainability.
- Increased consolidation among plans, with larger plans continuing to scale while "rolling up" smaller plans to achieve efficiencies and spread administrative costs.
- Further growth in private managed care, with a corresponding drop in new growth opportunities. Competition will be strong in re-procurements for existing programs, with emphasis on cost controls and ability to drive superior results.
- Added complexity as Medicaid beneficiaries' needs become more frequent and expensive. Growth opportunities remain in private managed care in serving seniors, the disabled and those requiring long-term care services and supports; however, plans will need to partner with vendors and service providers to supplement specialized capabilities.
- Comingling of Medicare and Medicaid enrollees. Forthcoming policies should build on private plans' foothold in Medicaid. The task will be to find a solution for individuals who tend to be caught between Medicaid and subsidized individual coverage.

As the provisions of the final rule are implemented, some Medicaid MCOs will fare well while others will struggle, be absorbed by other entities or vacate the market entirely. Issues of high-cost drugs, more complex membership needs, potential movement of the expansion populations to private options will all challenge Medicaid Managed Care organizations. The Medicaid and CHIP Managed Care Final Rule will provide guidance to the states and the plans to help both groups navigate the complexities of managed care delivery. ●

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Opioid Dosage Amounts and Acute Respiratory Distress

By Doug Brink, Pharm.D., BCPP

Medicaid recipients are prescribed opioids at twice the rate of non-Medicaid patients. Providers may be unsure and patients may be unaware of the risk of acute respiratory distress (RD) with opioids. Based on pain guidelines and data analysis, programs can implement morphine equivalent (ME) dosing limits that promote opioid safety.

Opioids are commonly prescribed for pain in the United States. It's estimated that 20 percent of patients who present to prescribers with acute or chronic pain complaints receive an opioid prescription.[1] In 2012, healthcare providers wrote 259 million prescriptions for opioid pain medication — enough for every adult in the United States.[2] While opioids may be effective for pain management, evidence indicates they are more beneficial in treating acute pain than for managing chronic pain.[3]

Opioid use is also associated with potentially serious risks. These include respiratory depression, overdose and development of opioid use disorder. The ability to predict and manage these potential risks remains an area of ongoing research. One area of interest in this regard is the possible association of daily dose of opioids — especially early in treatment — with potential adverse outcomes. This information could be useful for informing attempts to control exposure and limit risks. This report discusses an analysis performed by the Clinical Pharmacy Services team at Conduent regarding the risk of respiratory distress (RD) related to initial use of opioids at various dosage levels in Medicaid recipients.

All opioids depress all phases of respiratory activity (rate, volume and tidal exchange) and may produce irregular breathing. Clinically significant respiratory depression is not common with standard opioid doses, but the risk appears to be greater in patients who are opioid-naive, use higher daily doses, receive other CNS depressants and/or have coexisting conditions such as chronic pulmonary disease.[4]

In March 2016, the Centers for Disease Control and Prevention released guidelines for prescribing opioids for chronic pain. These guidelines recommend use of the lowest effective opioid dose, with reassessment for opioid morphine milligram equivalents (MME) ≥ 50/day and an avoidance of opioids ≥ 90 MME/day.[5] The dosing recommendations were supported by clinical studies that found higher opioid dosages are associated with increased risks for motor vehicle injury, opioid use disorder and overdose. Our analysis investigated the relationship between initial prescribed daily dose at three MME dose ranges and the incidence of RD in general, as well as in a subgroup of individuals with a history of RD.

Our data was presented as a poster at the Fall 2016 Academy of Managed Care Pharmacy (AMCP) Nexus meeting.[6] (Also see page 18.) We looked at a population of Medicaid lives and identified recipients continuously eligible from January 1, 2014 to December 31, 2015. Individuals who had any opioid utilization in 2014 were excluded. Those remaining (n=233,924) were divided into four groups:

- **Group 1** did not fill an opioid in 2015 and served as a control group.
- **Group 2** filled an opioid in 2015 with a daily dose of < 50mg MME.
- **Group 3** filled an opioid in 2015 between 50mg and 89mg MME.
- **Group 4** filled an opioid in 2015 ≥ 90mg MME.

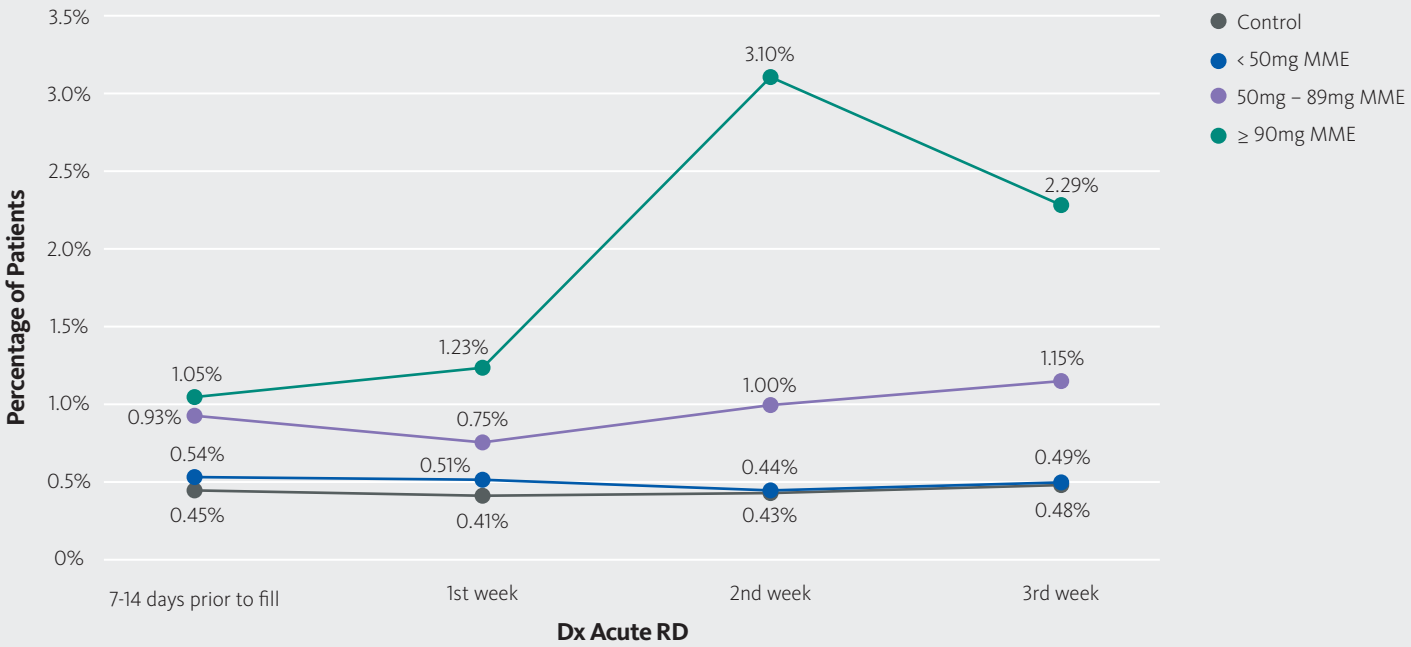
Group 1 included 211,510 recipients, Group 2 included 19,330, Group 3 included 1,941 and Group 4 included 1,143. The baseline incidence of acute RD was assessed 7 to 14 days before the first opioid fill in 2015 (or any prescription fill for the control group). The incidence of acute RD was compared for all groups for weeks one through three following the first opioid fill. The groups were further analyzed by separating the recipients into those with and without a history of any RD in 2014.

The incidence of acute RD among all eligible recipients (with and without prior RD) was similar across the 3-week time period for Groups 1, 2 and 3, who did not show substantial change related to receiving an opioid. However, Group 4 saw an increase in acute RD from 1.05 percent at baseline to 3.10 percent in week 2 post-fill (see Figure 1).

When the groups were analyzed further, by separating individuals who had a history of any RD in 2014 from those who did not, the results in those without a prior history mirrored the total population results. Recipients who had no history of RD and had a claim with MME ≥ 90mg (Group 4) increased from 0.92 percent at baseline to 1.55 percent in week 2 while the other groups did not substantially change. However, those with a prior history of any RD in 2014 appeared to have a greater sensitivity to the respiratory adverse effects of the opioid. Both Groups 3 and 4 saw increases in acute RD through week 3.

FIGURE 1

Overall Acute RD by Week of Onset After Opioid Fill



The increase from baseline to week 3 was 5.08 percent to 14.41 percent for Group 3 and 18.92 percent to 29.73 percent for Group 4 (see Figure 2).

Our data indicates that rates of acute respiratory distress increase most at daily opioid MME ≥ 90mg, and the rate of acute RD is higher among recipients with a history of RD. This data, along with the CDC guidelines, suggests that programs should implement clinical edits limiting opioid doses by a set milligram morphine equivalent.

More sophisticated edits that include a check for a history of RD (or other risk factors for adverse outcomes of opioids) would allow for restrictions related to lower opioid doses by stratifying recipients by risk. In addition, since providers may be unsure and patients may be unaware of the risk of acute respiratory distress, it would be to a state's advantage to implement educational activities for both groups to improve outcomes. ●

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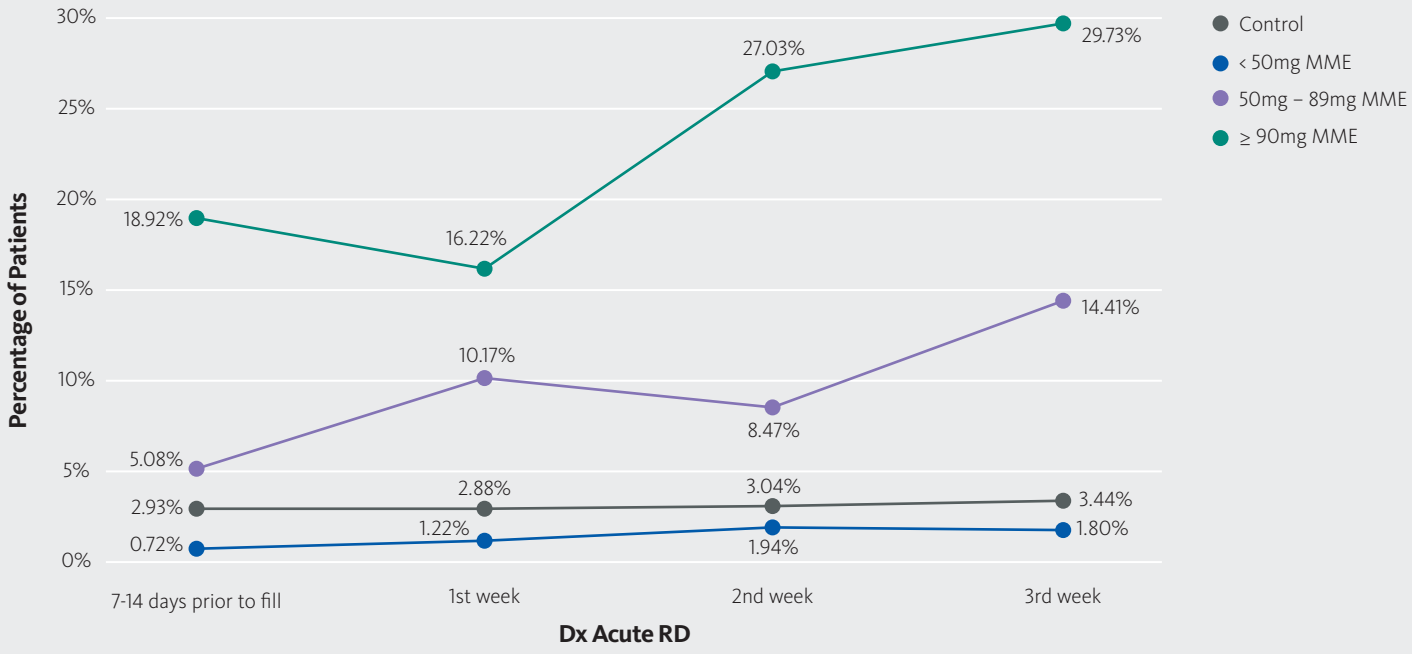
[5] Dowell D, Haegerich TM, Chou R. CDC guidelines for prescribing opioids for chronic pain — United States, 2016. Centers for Disease Control and Prevention. *MMWR* early release March 15, 2016. Available at: www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[6] Academy of Managed Care Pharmacy and Specialty Pharmacy 2016 Nexus Conference. Specialty Pharmaceuticals in Development. October 4, 2016. Available in: *J Manag Care Spec Pharm*, 2016; 22(10-a Suppl):S1–S100.

FIGURE 2

Acute RD by Week of Onset After Opioid Fill

History of RD in Past Year



Conduent Represented on MITA Governance Board

The Center for Medicaid and CHIP Services (CMCS) Management formed a Medicaid Information Technology Architecture (MITA) Governance Board that met for the first time this past December.

Jeff Strand, Sr. Business Architect for Conduent, was selected as one of its initial board members. Jeff has been working with the MITA Framework since its inception and is currently a co-chair of the National Medicaid EDI HIPAA (NMEH) MITA work group. He is also an active member of the MITA Technical Architect Committee.

The objectives of MITA Governance Board are to identify MITA enhancement opportunities and align them with MITA strategic goals and objectives.

In addition, the Board is tasked with directing the growth and evolution of the MITA framework, along with ensuring that the MITA baseline guides the implementation, improvements, and certification of Medicaid Enterprise Systems projects.

Finally, the Board is responsible for making sure the MITA framework adheres to Medicaid regulations, policies, procedures, guidance and technical standards, and that proposed MITA enhancement opportunities are duly vetted, accepted and implemented.

The MITA Governance Board will be a voluntary body primarily asked to identify, prioritize and refer significant MITA evolution opportunities to CMCS management. It will also be responsible for helping to identify and establish working groups as needed.

The board consists of up to 12 individual members and two alternates with expertise in issues related to Medicaid, Medicaid IT, Medicaid claims processing and Medicaid provider operations. They will have expertise in software-intensive systems requirements elucidation, design, architecture, development, integration, implementation, testing, operations and maintenance.

As a group, the board will coalesce input from the stakeholder community into improvement opportunities, along with offering sound and timely individual operational recommendations to facilitate CMCS decision making, acceptance and implementation. In addition, these members will select working groups to review or complete specific priorities.

The MITA Governance Board was selected from various MITA stakeholder organizations such as federal partners, state partners, nonprofit organizations, state marketplaces, associations and vendor groups.

"Healthcare, particularly Medicaid, is evolving rapidly. It is important that one of the key frameworks that support standardization — and flexibility — in Medicaid solutions has proper governance."

Jeff Strand, Senior Business Architect, Conduent

"I am honored to have been chosen to continue to support the MITA initiative as a member of the Governance Board," Jeff stated. "Healthcare, particularly Medicaid, is evolving rapidly. It is important that one of the key frameworks that support standardization — and flexibility — in Medicaid solutions has proper governance. This will allow for the continued evolution and refinement of MITA to keep it relevant in a changing environment." ●

Network Adequacy Monitoring Improves Access to Care

In April 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revised and strengthened existing Medicaid managed care rules.

The Medicaid Managed Care Final Rule requires state programs to maintain accessibility standards for providers serving members. But because standards varied widely from state to state and did not account for population size, needs or location, programs were susceptible to unused services, suboptimal health outcomes and higher program costs.

The Need for a Reliable Solution

A 2014 Office of Inspector General (OIG) audit found that most states weren't monitoring network adequacy in line with the Medicaid Managed Care Final Rule's requirements. What's more, the standards for determining adequacy are inconsistent. One primary care provider can serve anywhere from 100 members to 2,500 members depending on the state — and they often don't account for high-demand specialists like pediatricians and obstetricians.

To overcome the challenge of ensuring network adequacy, Conduent now offers a Network Adequacy Monitoring solution that supports the Medicaid Managed Care Final Rule and helps Medicaid members access care closer to home.

An Innovative Approach

The Network Adequacy Monitoring solution enables states to develop network adequacy standards and monitor programs objectively for compliance. It also gives states a powerful resource for direct validation of provider directory information and more reliable evaluation of compliance.

The solution is based on a software suite of tools for measuring healthcare network adequacy using geographic coordinates of healthcare provider locations. It's an innovative approach designed to provide better accuracy in measuring networks and enable programs to establish access standards for the actual accessibility of healthcare providers.

Improving Access Means Lower Costs

Through our Network Adequacy Monitoring solution, your members benefit from access to healthcare services nearby. This allows them to get the help they need when they need it and lowers costs for your program.

While some commercial solutions try to adapt existing technology to CMS standards, we combine our 40 years of Medicaid experience with proven network adequacy monitoring technology that's used today in many commercial applications as well as federal agencies and programs.

Our easily implemented, standalone solution helps you quantitatively develop objective provider network adequacy standards that account for the size, location and care required by the populations you serve. It then continually monitors and evaluates the provider networks in your managed care plans, ensuring that they meet the standards your program has defined. ●

Important Dates for Compliance

There are three key dates in the phased approach for network adequacy monitoring compliance:

July 1, 2017: States begin developing protocols for validation of network adequacy.

July 1, 2018: States submit the protocols for validation of network adequacy to CMS.

July 1, 2019: States begin conducting mandatory network adequacy validation.

You can learn more about our new Network Adequacy Monitoring solution at **conduent.com/govhealthcare**.

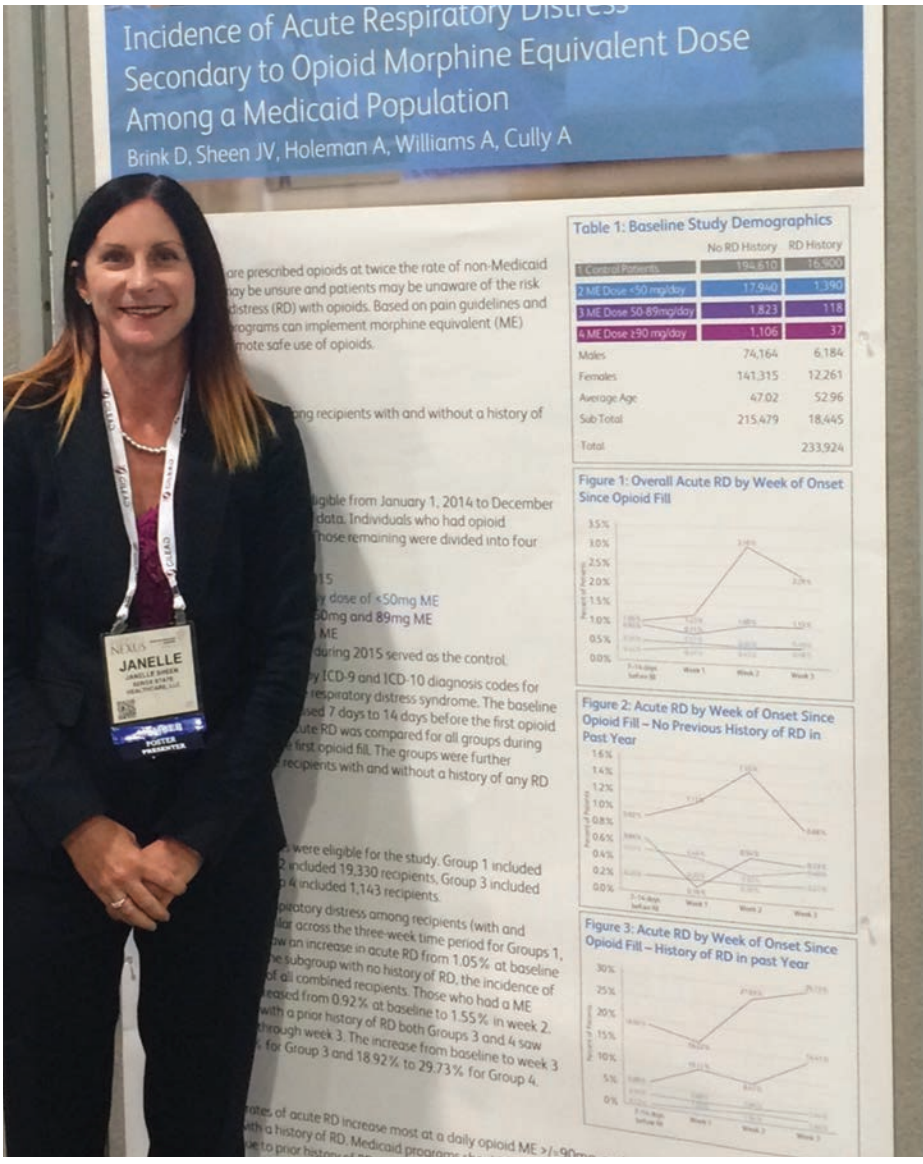
AMCP Awards Conduent Pharmacy Team

The Clinical Services team in Conduent's Pharmacy Benefit Management group was recently awarded a silver medal for a poster session presentation during the Nexus 2016 event hosted by the Academy of Managed Care Pharmacy October 3–6, 2016 in National Harbor, Maryland.

There were just over 250 poster presenters accepted at Nexus 2016, two of which were submitted by the Conduent team. The abstracts were ranked on a 1–5 scale according to five criteria: relevance, originality, quality, bias and clarity. Four posters received a platinum medal, 12 received gold, 10 silver and 21 bronze.

Our team's silver-winning abstract was titled "Incidence of Acute Respiratory Distress Secondary to Opioid Morphine Equivalent Dose among a Medicaid Population." In it, they outlined research the team conducted on trends in acute respiratory distress (RD) in Medicaid recipients both with and without a history of RD across three morphine equivalent dose ranges. In keeping with Nexus 2016's theme of "Connecting Innovation and Healthcare," the results of the team's research can guide Medicaid programs in developing clinical edits for appropriate opioid doses as well as guide educational interventions to raise awareness of acute respiratory distress risks.

The abstract was published in a supplement to the October 2016 issue of the *Journal of Managed Care & Specialty Pharmacy* Vol. 22, No 10-a. (You can also read an expanded version of the team's research on page 14.)



Janelle V. Sheen, Pharm.D.: Director — Clinical Services, Government Healthcare Solutions

Conduent Launches Form 1095-B Management Solution

Dealing with Form 1095-B — the proof of coverage required by the Affordable Care Act (ACA) — is a headache for Medicaid programs. This latest challenge involves health insurers being required to file their members' coverage confirmation with the IRS and subsequently providing members with a 1095-B coverage statement form.

The Form 1095-B process seems simple on the surface, but it's much more challenging for Medicaid. For example, program members typically have variable coverage periods and require retroactive eligibility changes. This can be a problem for commercial 1095-B filing systems that can't accommodate this kind of flexibility.

Conduent modernizes the 1095-B process by bringing mailing, filing and member support into an end-to-end, automated solution. We've combined our decades of Medicaid knowledge — and member contact support — and the tax system expertise of Thomson Reuters into an end-to-end Form 1095-B management solution. It not only removes your administrative burdens of managing tax forms and filing; but it also takes on the responsibility of helping your members get answers to their 1095-B questions. It enables your program to stay focused on improving health outcomes and keep your members compliant.

Integration and Compliance at a Lower Cost

Our Form 1095-B management solution is a Software-as-a-Service (SaaS) platform hosted in a secure data center and accessed through a standard browser. Because it's web-based, you avoid the need to buy, upgrade or manage any hardware or software. Future updates are delivered online directly, saving your program time and money.

This approach not only makes it easier for you to comply with all IRS and ACA regulations for Form 1095-B generation and filing, but it was developed with Medicaid's rules in mind. In particular, our solution gives you the flexibility to accommodate members who frequently move in and out of your program. It also enables you to assist members who require retroactive changes to eligibility and who are enrolled in other assistance programs.

Finally, because system updates can be delivered automatically as regulations evolve, you can adapt quickly to any future healthcare legislation or tax code changes to the 1095-B process.

Be More Responsive to Members

Conduent's new solution not only supports 1095-B generation and mailing, but also allows you to respond efficiently to member inquiries. We can quickly ramp up call centers dedicated to 1095-B support, taking the strain off of your program during tax season.

Moreover, our teams can answer general questions, process requests for reprints, make corrections to forms and even process return mail. We can provide immediate service in English and Spanish, as well as take questions in more than 200 other languages through a translation service.

Self-Service for Program Members

The solution helps you empower members with more control over how they receive their Form 1095-B. Instead of waiting for you to mail a form, they can opt out of hard copies and view their form through your public portal.

Members can also use the portal to print, reprint or request corrections to the form, as well as submit questions online — anywhere, anytime. With a self-service option, you can save your members time and provide them with a more engaging, interactive experience with your program.

Make Better Use of Your Time — and Your Members'

With the Conduent Form 1095-B solution, your members benefit from a seamless, personalized experience with your program and less stress during tax time — something that translates into greater customer satisfaction and higher quality rankings for you. ●

For more detailed information about our new Form 1095-B solution, please visit **conduent.com/govhealthcare**.

YOUR NEWS

Louisiana Extends Partnership with Conduent

The State of Louisiana recently strengthened its partnership with Conduent, extending the current contract to support their Louisiana Department of Health's Office of Aging and Adult Services (OAAS).

The state has asked Conduent to support several projects over many years, beginning with initial telephone screenings and program call center support in 2004. We conducted face-to-face assessments for elderly and disabled adults and determined the functional eligibility of program participants for over 12 years. OAAS and Conduent have grown together to provide a single point of entry for all applicants needing long-term care services and supports across Louisiana.

OAAS currently serves more than 12,000 program participants. The program's goal is to enable people to remain in their homes and communities, as well as to connect them with the resources that they need to maintain their independence. Over the past five years, the teams supporting the program have completed more than 43,000 level of care assessments and provided over 41,000 monitoring encounters of program participants. For Louisiana, it's a win-win scenario. The program allows participants to stay in their homes where they want to be, while helping the state avoid the high costs of healthcare in institutional settings.

Under the partnership, Conduent supports eligibility for Louisiana's Long Term Personal Care Services (LT-PCS) and screening services for Louisiana Department of Health waiver programs. This includes telephonic screening to determine participants' program eligibility, face-to-face assessments for functional eligibility and care planning for participants that are not in managed care programs. To ensure participants' health outcomes are improving, we regularly monitor

"OAAS was very grateful for Conduent's quick reaction during the Flood of 2016. There is no way we could have reached out and helped all the recipients and continued our mission without their work. The whole time we felt they were a part of us and we all knew they were a part of our team. Everyone in LDH knows we consider them our team. It helps to know they are with us."

Gina Rossi
Program Manager
Long Term Personal Care Services Manager
Office of Aging & Adult Services

program participants by making calls and visits to confirm if they are receiving their authorized services and that there aren't any problems in the home such as abuse and neglect. Conduent also processes appeals and represents OAAS in appeal hearings for participant disputes with program requests and determinations.

The methods of assessment have become thoroughly modernized through this partnership. Assessments are performed in the applicant's home, and the information used to be recorded manually and then reviewed and analyzed once the assessor returned the office. The plan of care would then be finalized and mailed to the participant and caregivers — a weeks-long process. With innovations in mobile and online technology, assessors can now record applicants' information with laptops and other devices, upload it to a central database via the internet, perform the analysis remotely and establish a plan of care — all before leaving the participant's home.

Another important part of the OAAS program is the contact center, which provides ongoing assistance to participants, their caregivers and other members of a participant's circle of support. Since 2011, it has assisted over 180,000 callers. The center provides callers with comprehensive information about the many OAAS program options for long-term services and supports and monitors participant's transfers between programs to make sure that they do not have any adverse effects from the transition.

The contact center also refers callers to non-LDH agencies and community-based organizations. When a team member uncovers a need, or if a participant expresses a need for resources, the center can use its resource database of over 2,500 resources (such as Meals on Wheels and the American Cancer Society) that can provide additional services to the elderly and disabled adult population throughout the State of Louisiana. To date, there have been more than 29,000 community referrals through the contact center (and another 80,000 through in person assessments).

Louisiana and Conduent are currently building on the successes with improving the lives of the state's long-term care recipients. Upcoming initiatives include planning for possible future updates to the state's long-term services and support program to a managed care model. ●

Mississippi Completes Eligibility Modernization Project

In August 2016, Mississippi moved a step closer to a fully integrated eligibility system with the completion of its modernization project.

The initiative successfully consolidated enrollment processes for the state's Aged, Blind and Disabled (ABD) and Families, Children and CHIP (FCC) populations. The culmination of four years of work, Mississippi has streamlined enrollment processes and is connecting members to the services they need more quickly.

The effort began in 2012 when the Mississippi Division of Medicaid conducted research on the ABD and FCC programs and found that they shared many members. As a result, there was a great deal of duplicated enrollment effort; the state was also collecting similar information from the same people. At the same time, then-new guidelines from CMS introduced limits on the turnaround time for determinations and automation requirements across multiple systems. The time was right to revamp their approach.

Developing the Strategy

The state first set about determining its modernization priorities. Obviously, streamlining ABD and FCC eligibility was important; there was no need to make people go through similar processes twice. But more than that, Mississippi Medicaid wanted to increase accessibility to its services. At the time, program applicants had to visit regional offices in person to begin their eligibility determination. This approach had become a barrier to getting people connected with the services they needed to improve their health. The ultimate goal was to have "no wrong door" access: people should have the ability to apply for benefits by sending a form via mail, email or fax or by visiting or calling a regional office to speak with an eligibility specialist.

Mississippi has partnered with Conduent for many years to provide support that benefit Medicaid members. We manage the state's MMIS, act as the program's fiscal agent and provide several other services. Because of this long, successful collaboration — and because of the insights we gained while supporting eligibility processes for the ABD and FCC programs — the state asked the Conduent team to be involved in the modernization project.

Having maintained two eligibility systems for years, the original approach was to merge the ABD population into the FCC system. However, further analysis showed that it was better to develop a completely new system from the ground up that incorporated eligibility for both populations. This would not only streamline the processes and reduce redundancies more quickly; the fresh start would also be more effective in the long run by better positioning the program with a more efficient approach for alignment with future federal and state regulations.

Merging the Programs

Merging the two programs involved implementing more automated processes and using a rules engine for eligibility determinations rather than continuing with manual determinations. Because this approach would introduce objective standards for determinations instead of relying on each individual worker's interpretation, the determination criteria and outcomes would be more consistent. The rules engine could also lighten the per-applicant workload on eligibility program staff, enabling them to process more program applications.

The final implementation was mostly seamless and used innovative techniques. As parts of the new eligibility system were developed, they were presented to users in a test environment. This enabled the program staff to try out the functionality before each of the phased implementation steps and uncover potential issues before the final implementation. This test environment also provided "draft" views of the system as a whole. Users could see what changes had been made to a previous version and confirm the changes were approved for each release. The overall implementation was also noteworthy because of its Waterfall/Agile approach. Instead of being locked into a long series of tasks defined at the beginning of the modernization project, the team had the flexibility to spot and address unmet needs during testing.

New Process, New Efficiencies

Overall, the response of the Mississippi Medicaid staff has been favorable to the new eligibility system's performance. The facilitated determination process has created efficiencies in caseload management. Before merging ABD and FCC eligibility, the state processed an average of 50,000 applications per month between the two programs; under the new system, the average has increased to 70,000 applications per month. In addition, the system provides a more streamlined training process for new employees. The state has found that new employees can become proficient more easily and quickly across a broader range of system activities than before.

"We appreciate Conduent's commitment to improving the lives of Mississippi's citizens through enhanced access to quality healthcare," said Dr. David Dzielak, Executive Director of the Mississippi Division of Medicaid. "As a result of their groundbreaking technology work in strong partnership with our eligibility program staff, Mississippi is reaping the benefits of a modernized eligibility system."

In the next few years, Mississippi plans to continue its modernization initiatives, including SNAP and TANF, with the goal of having a fully integrated eligibility system for the populations it serves. ●

Before merging ABD and FCC eligibility, the state processed an average of 50,000 applications per month between the two programs; under the new system, the average has increased to 70,000 applications per month.

Sharing ideas drives innovation. That's what Conduent does with *HealthFocus* — highlight new ways government healthcare programs can improve health outcomes. We cover topics related to our industry, news about our business and specific issues you deal with every day. Our goal is to capture the vast array of information that affects us all and encourage conversations that broaden our perspectives.

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