Realizing Better Outcomes at a Cost Governments Can Afford

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Seeking Stable Ground in a Shifting Landscape

It has been a rocky road for health and human services (HHS) leaders as they have grappled with sweeping changes that came with the Affordable Care Act (ACA). While some states successfully rolled out ACA components such as health insurance exchanges (HIXs) — albeit with a few minor hiccups — others faced serious hurdles and setbacks.

Even after states’ HIXs were functional, questions remained, particularly as two cases before the Supreme Court threatened to alter or fully derail the ACA. The first, National Federation of Independent Business v. Sebelius, questioned the constitutionality of the individual mandate.1 The second, King v. Burwell, contended subsidies should not be issued to individuals who buy health plans through a federally managed exchange (as opposed to a state-based exchange). At the time of the court case, 34 states relied on a federal exchange with millions of Americans enrolled.2

In both cases, the Supreme Court sided with the Obama Administration, but challenges to the law are likely to result in continued volatility for HHS agencies. Regardless, most states would likely agree the chaos that reigned in the early days of the ACA has passed and they are seeking — and sometimes finding — more stable ground five years later.

However, leaders must still find answers to tough questions, including the biggest one: How do we provide effective, comprehensive care and services in a way that is fiscally sustainable? Meanwhile, legislatures are still debating if their states should expand Medicaid and, if so, to what degree. State officials are contemplating approaches such as managed care, integrated eligibility and paying for performance to reduce unnecessary costs and improve outcomes. CIOs are undertaking efforts to implement robust network services for telemedicine solutions to improve access — particularly in rural areas. They’re also implementing technologies to glean greater insights from data and analytics to support preventive care, improve services and reduce fraud, among other things.

Importantly, at the center of this is people — individuals and families who may be struggling with a plethora of physical, mental, social and financial challenges, which are often interconnected in a web of complexity. State and local governments are increasingly aware of the linkages between health and human services and the reality that if we are to solve the problems of one, we need to address the challenges of the other.
For the first time, the Centers for Medicare and Medicaid Services (CMS) project health care will hit a cost of $10,000 per person, for a total of $3.207 trillion, in 2015. But despite the fact the United States spends more per capita on health care than any other industrialized nation, it consistently ranks last or near last in terms of outcomes when compared to health systems in European and Scandinavian countries.1

This exorbitant expense — and lack of positive results — is troubling for state and local governments that help shoulder the costs of Medicaid and the Children’s Health Insurance Program (CHIP). Most of what we see happening in HHS agencies — and many of the trends we will discuss in this report — are a result of the need to reduce costs and improve outcomes.

Medicaid: To Expand or Not to Expand?

One bone of contention with the ACA — usually split along political party lines — has been Medicaid expansion. While the ACA extended Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines, the Supreme Court ruled a state’s existing federal Medicaid funding was not contingent on its decision to expand — essentially rendering Medicaid expansion a voluntary act.

Since the passage of the ACA (and at the time of this writing), 31 states (including the District of Columbia) have expanded Medicaid, 1 state is discussing expansion and 19 states have not expanded. Proponents say Medicaid expansion will save the federal government and state governments money in the long term — as well as provide insurance to millions more individuals who are currently uninsured. Critics argue states cannot afford the ultimate

In June 2015, the Governing Institute and the Center for Digital Government conducted a nationwide survey of 285 state and local government leaders about the status of health and human services in their jurisdictions, the challenges they face and how they are working to overcome them. Unless otherwise noted, the research in this report is a result of this survey.

What are the most effective ways to reduce costs and improve outcomes in health care?

<table>
<thead>
<tr>
<th>Preventive care</th>
<th>77%</th>
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<tbody>
<tr>
<td>Improve diagnosis and care for mental health</td>
<td>45%</td>
</tr>
<tr>
<td>Improve collaboration among health and human services agencies</td>
<td>44%</td>
</tr>
<tr>
<td>Reduce health insurance costs</td>
<td>38%</td>
</tr>
</tbody>
</table>

Data and analytics

| Incorporate greater business efficiencies with increased use of IT and automation | 26% |
| Cap malpractice suits                | 21% |
| Telemedicine                          | 16% |

Source: Governing Institute HHS Survey, 2015
Iowa, Michigan, Pennsylvania, New Hampshire and Indiana had received approval to implement Medicaid expansion in ways that do not meet federal rules, but still access federal matching funds for newly eligible adults. Some of the caveats include charging premiums to enrollees, eliminating certain required benefits and using health behavior incentives.

While state leaders contend the compromises make Medicaid more fiscally sustainable for their states, others argue the changes are overly harsh to economically challenged populations. It remains to be seen how far the federal government is willing to let states go in making exceptions, but Medicaid has long been a petri dish for innovation, whereby states experiment with different models. This is likely to continue.

Managed Care: Not New, But Better?

The origin of managed care dates back to at least 1917 in the United States. It has been around for almost a century and continues to increase in popularity despite differing opinions on whether it’s a successful approach to improving outcomes. Critics say managed care simply transfers the risk to private companies rather than the government, and the long-derided fee-for-service (FFS) model — in which doctors and health care providers are paid for each service performed — still reigns in many managed care plans. They also contend some managed care organizations (MCOs) have inadequate networks of doctors and those plans can vary drastically from state to state, among other arguments.
Ohio is revamping its managed care program. In 2012, the state initiated several changes. The modifications included linking health plan payments to performance, integrating care delivery for Medicare-Medicaid enrollees (dual eligibles) and providing more accountable care for children with disabilities.

The state’s changes appear to be working. According to a report released in August 2015 by Gov. John Kasich’s administration, total Medicaid spending was $23.5 billion in the fiscal year that ended June 30 — 7.6 percent less than projected.

In addition to expanded managed care, those savings are attributed to adding more home-based care for seniors, shortening nursing home stays and capitated reimbursement policies.

**Paying for Value Instead of Volume**

In January 2015, the Department of Health and Human Services announced its goal of tying 30 percent of traditional FFS Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

The move was the latest in an increasing shift away from the traditional (and problematic) FFS model to a system that rewards value rather than volume. FFS has long been lambasted as doing nothing to reduce avoidable hospital readmissions or expensive emergency room visits. While FFS is the dominant payment model for providers under Medicaid — even in states where MCOs

Despite these qualms, more than half of all Medicaid beneficiaries nationwide receive most or all of their care from risk-based MCOs. According to the Kaiser Family Foundation, 39 states, including the District of Columbia, have contracts with a comprehensive Medicaid MCO, and all but 3 have some form of managed care. By the end of 2015, 46 million Medicaid beneficiaries are expected to receive their health coverage through private plans.

In May 2015, CMS proposed updates to Medicaid managed care rules in an attempt to improve outcomes. The major changes include:

- **Quality ratings.** While Medicare has a five-star system evaluating private plans, there is currently no national standard for Medicaid managed care plans.
- **Medical-loss ratio.** CMS would set an 85-percent standard, meaning 85 percent of insurers’ revenue must go to medical costs (versus administrative expenses and profits).
- **Network adequacy.** CMS would require states to set standards on how long patients should wait or travel to see a doctor.
- **Long-term care.** CMS would mandate for managed care to comply with federal law, which requires plans to provide care in the least restrictive setting possible. This would encourage the use of at-home care (as opposed to nursing homes).
- **Accreditation and monitoring.** The CMS proposal sets out at least 14 areas states would have to collect data on to provide baseline comparisons.

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are common — new, innovative models are beginning to emerge.

State Innovation Models Initiative. Part of this innovation is stimulated by CMS’ State Innovation Models (SIM) Initiative, which is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models. The aim is to improve health system performance, increase quality of care, and decrease costs for Medicaid and CHIP beneficiaries, as well as for all residents of participating states.

The SIM Initiative has already doled out hundreds of millions of dollars in awards to states to both design and test innovative health care payment and service delivery models. During round one of the initiative, nearly $300 million was awarded to 25 states. The states selected to test their model included Oregon, Vermont, Massachusetts, Arkansas, Minnesota and Maine. Round two recipients, announced in December 2014, were awarded more than $660 million. Thirty-two states were granted an award and 11 states were selected to test their model. These states included Washington, Idaho, Colorado, Connecticut, Delaware, Iowa, Michigan, New York, Rhode Island, Ohio and Tennessee.

Some of the innovative plans these states are implementing include:

- **Arkansas** — By 2016, a majority of Arkansas residents will have access to a patient-centered medical home, which will provide comprehensive, team-based care with a focus on chronic care management and preventive services. (For more information on Arkansas, see “Arkansas Crunches Numbers for Insight into Medicaid Patient Journey” on page 10.)

- **Maine** — The state is aligning benefits from its Medicaid program with benefits from Medicare and commercial payers to lower costs for Medicaid, Medicare and CHIP populations while improving access and quality. The model will support the formation of multi-payer ACOs committed to providing greater value in return for performance-based payment.

- **Colorado** — The “Colorado Framework” will provide access to integrated primary care and behavioral health services in coordinated community systems, as well as apply value-based payment structures and expand IT efforts (including telehealth). The state is also integrating physical and behavioral health care in primary care practices and community mental health centers.

While each state’s model is unique, there are consistencies. Among them: coordinating care; aligning multiple benefits programs to reduce redundancies; focusing on population health; using technology to lower costs and improve access; and integrating primary, behavioral and mental health.

**Delivery System Reform Incentive Payments.** Similar to the SIM Initiative, Delivery System Reform Incentive Payments (DSRIP) provide federal funding to states with innovative solutions to help transform the health care delivery system. DSRIP programs focus on measurable outcomes based on a set of metrics. States with approved DSRIP projects include California, Kansas, Massachusetts, New Jersey, New Mexico, New York and Texas.

Key elements present in state DSRIP programs include innovative payment reforms, consistency in performance metrics, information technology and population health, and collaborative learning and infrastructure.

New York’s DSRIP program is incentivizing value over volume. The state is targeting a 25 percent reduction in avoidable hospital use over the next 5 years. The New York program is pay-for-results (moving away from fee-for-service) and DSRIP funds will only go to performing provider systems (PPSs) that successfully achieve targets to measurable health outcomes. The state’s goal at the end of the 5-year program is to have 90% of all MCO Medicaid payments be value based.

Historically, the big-bang approach has resulted in systems that take longer to deploy and are more expensive than initially scoped. We’ve said we don’t want to pay for that approach anymore.”

— Jessica Kahn, Director, Data and Systems Group, CMS

MMISs and Moving Away from the Big-Bang Approach

Costing anywhere between $50 million and $150 million, Medicaid management information systems (MMISs) are one of the largest IT investments a state makes. They’re also notoriously complex, with thousands of intricate business rules and extensive custom development.

In response, public agencies and their industry partners often confront the complexity and scale of the challenge using an approach to develop these systems that can best be described as a “big bang.” These deployments take years to complete, during which time state requirements and Medicaid regulations are frequently modified. But this is changing.

“Historically, the big-bang approach has resulted in systems that take longer to deploy and are more expensive than initially scoped,” says Jessica Kahn, director of the data and systems group for CMS. “We’ve said we don’t want to pay for that approach anymore.”

CMS proposed new rules in April 2015, which encourage a modular or incremental certification process for MMIS deployments with updated policies for receiving enhanced federal matching funds as each module is certified. CMS is also talking with states that are in the process of replacing their current MMIS, discussing how
The state of Arkansas has emerged as a ground-breaking innovator on strategies to incentivize and enable providers to achieve better results at a lower price point. In 2011, the state embarked on the Arkansas Health Care Payment Improvement Initiative. Two important components of the initiative were creating episodes of care — which is a collection of care provided to treat a particular acute condition for a given length of time — and patient-centered medical homes, whereby patient treatment is coordinated through a primary care physician to ensure they receive the necessary care when and where they need it.

The state first selected five episodes of care — hip and knee replacement, congestive heart failure, upper respiratory infection, attention deficit/hyperactivity disorder and perinatal — and then recorded all expenditures related to the episode of care within a certain amount of time (typically 30 to 60 days). By doing this, the state could determine an average cost for each episode of care and communicate this to accountable care providers — those doctors or hospitals who would serve as the central point for episodes of care in the future.

“We used our claims warehouse in an increasingly sophisticated way to manage claims data and create an accounting of all of these services. We then created report cards so the accountable provider could see the total cost of care and determine where their patients, on a risk-adjusted basis, spent dollars when compared to peers,” says Dr. William Golden, medical director of Arkansas Medicaid. “Our episodes of care and patient-centered medical homes programs have each crunched about 350 million claims to create these report cards.”

Providers who have below-average costs reap 50 percent shared savings of their average cost per case below the threshold. Providers who have high costs must share in those costs. The result is a system where providers have a baseline for where their costs should be and incentives to ensure patients recover without expensive and avoidable procedures and interventions.

Arkansas also created patient-centered medical homes, which are more conducive to chronic disease management and prevention, as opposed to acute illnesses. The state has now added episodes of care and plans on establishing up to 15 in the coming years.

Golden says both providers and payers have largely been on board. “Some of our better and more efficient clinicians have said, ‘Hey, for the first time in my career someone is going to pay me more for doing a better job.’”

Through data, the state is providing insight into the total patient journey. Armed with this information, the accountable care provider can modify the total amount of resources it should take to deliver services. “It’s clear that timely data is essential for the episodes as it equips the providers with the roadmap for how to improve,” Golden says.20

Wyoming has already adopted an MMIS-as-a-service model and expects to launch a series of procurements this year for services-based MMIS modules to replace its 30-year-old mainframe technology.

“We want to contract for services, and we don’t want all of those services to be with one vendor,” says Teri Green, Wyoming’s Medicaid director. “Standing up a new traditional MMIS is very costly and time consuming, and continuing to operate our old system doesn’t make good business sense.”

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— Dr. William Golden, Medical Director, Arkansas Medicaid
Dr. William Golden, medical director of Arkansas Medicaid, helped the state use its claims warehouse data to report care costs to accountable providers.
The Struggle to Help People in Need:
Challenges and Trends in Human Services

The recession was tremendously difficult for human services agencies. Many of them saw sharp increases in the number of people who needed assistance, including individuals and families who had never before sought government help. At the same time, these agencies grappled with budget decreases and took a backseat as states spent time and energy on implementing components of the ACA, most notably the HIXs.

The silver lining of these issues is human services agencies have increasingly looked to smarter policies that encourage collaboration and the sharing of data to be more efficient and create better outcomes with less work. They are also adopting technologies that allow them to increase access and make more informed decisions.

Poverty, Hunger and Homelessness: Pervasive Ills

Are poverty, hunger and homelessness getting worse? There are differing opinions, largely because it depends on which years you compare. A 2014 Census Bureau report noted poverty had declined from 15 percent to 14.5 percent from the previous year. While the report attributed this decline to a drop in children living in poverty, another report noted child poverty reached its highest rate in 20 years, increasing by 2 percentage points between 2008 and 2012. Currently, 16 million children live in poverty in the U.S. — one of the richest countries in the world.

The U.S. Conference of Mayors surveys 25 cities every year on homelessness and hunger, as well as their budgetary capacity to provide services. Among their findings:

- The number of families experiencing homelessness increased across the cities by an average of 3 percent over the last year.
Other communities are being proactive about identifying people in need and providing assistance before an individual or family finds themselves in crisis. Over the last two years, the National League of Cities (NLC) Institute for Youth, Children and Families (YCF) has been working with five cities — Houston, Louisville, Ky., Newark, N.J., Savannah, Ga., and St. Petersburg, Fla. — to help low-income families pay their utility bills and achieve financial stability. The LIFT-UP program is innovative because it uses missed utility bills as an opportunity to identify individuals and families who are likely on the brink of financial crises and works to provide resources and social services to them before their situation becomes more dire.27

Confronting Poverty

As governments look for ways to help citizens in need, they should not underestimate the power of basic and traditional government services. For example, robust public transportation options and strong public education systems can make significant strides in bolstering economic mobility for low-income and poverty-stricken citizens.

Ester Fuchs, the director of the Urban and Social Policy Program at Columbia University's School of International and Public Affairs, says mayors and other local government leaders in particular have a huge opportunity to move the needle on poverty. "Mayors can create policies that have a long-term impact on poverty and the ability to create economic mobility for city residents," says Fuchs, who was also a special adviser to NYC Mayor Michael Bloomberg. "Mayor de Blasio's universal pre-K program is one example," Fuchs says. "Early learning for kids is extremely important and impacts their capacity to learn down the road. Mayor de Blasio was successful at getting the state to fund universal pre-K — $300 million for 5 years. Low-income families will be huge beneficiaries of this over time."26

Recent budget cuts to the Supplemental Nutrition Assistance Program (SNAP) have made addressing hunger more difficult. While SNAP funding increased in the wake of the recession, the additional funding was not permanent, and the number of food insecure households is now close to what it was in 2008 — 14.6 percent then compared to 14.3 percent now. Across-the-board cuts to SNAP benefits beginning in late 2013 totaled $5 billion in just 1 year, which reduced the monthly benefits for every SNAP participant in the country. While some of the funding is being redirected to programs such as the Healthy Hunger-Free Kids Act (HHFKA), additional cuts are scheduled for this year and next.25

HHS leaders believe poverty and homelessness are:

- Becoming a much larger problem than in the past: 62%
- Remaining relatively steady: 37%
- Not as big of a problem as they were in the past: 1%

Source: Governing Institute HHS Survey, 2015
Solving Chronic Homelessness

Sixty-two percent of individuals surveyed in the Governing Institute’s HHS survey said they felt poverty and homelessness are a “much larger” problem now than in the past. However, despite this, there have been recent successes in reducing homelessness. The U.S. Interagency Council on Homelessness (USICH) works to coordinate the federal response to homelessness by helping federal agencies collaborate, and assists states and local communities in strengthening their efforts. A major focus for USICH has been working with the U.S. Department of Veterans Affairs (VA) and the Department of Housing and Urban Development (HUD) on interagency strategies and initiatives for ending veteran homelessness. For example, through the 25 Cities Initiative, agencies jointly coordinate technical assistance to communities experiencing high levels of veteran homelessness. As of August 2014, the cities involved in this initiative had housed more than 10,000 individuals.

Some of the greatest success stories include Salt Lake City, which ended chronic homelessness among veterans in early 2014, and New Orleans and Houston, both of which effectively ended veteran homelessness in 2015.

Matthew Doherty, executive director of USICH, says there are key elements the agency sees in these communities, including:

- Operating like a system and using a full range of programs and services in response to homelessness
- Creating a “by-name list” of everyone experiencing homelessness in the community
- Assessing veterans experiencing homelessness and understanding their needs and goals
- Implementing a “housing first” approach, which removes barriers and prerequisites and prioritizes providing access to permanent housing as quickly as possible

In Washington, D.C., Brenda Donald, the deputy mayor for Health and Human Services, says the district’s Interagency Council on Homelessness laid out its five-year plan to end family homelessness by 2017 and veteran homelessness by the end of 2015. By the end of 2022, the goal is for homelessness to be “rare, brief and non-recurring.”

“When we say ‘end homelessness,’ we don’t mean that no one will be homeless at all, because life happens and we can’t prevent that. However, if an individual or family is homeless, we want it to be a temporary situation and we want to have the systems and resources in place to move them quickly to permanent housing,” says Donald.

Combating Hunger

The school lunch program has long been a way to feed school-age children during the school day, but the linchpin has been the school itself. Due to food insecurity issues at home, some children rely on school to provide the only real meal they eat each day.

The federal Afterschool Meals Program, a subset of the Child and Adult Care Food Program, addresses this by reimbursing city agencies, schools and nonprofit organizations that provide nutritious meals at afterschool and weekend programs for children and youth. The program was made possible by the Healthy Hunger-Free Kids Act in December 2010 and is available in all 50 states. Afterschool programs are eligible for federal funding if they have an educational or enrichment component and are located in an area in which at least 50 percent of the children qualify for free or reduced lunch.

The problem is it’s not widely used. Recognizing this, NLC has, for several years, awarded grants to various cities through its “Cities Combating Hunger through Afterschool Meals Programs” to help communities take advantage of available funding.

NLC provides cities with customized assistance, access to best practices and national experts, and opportunities for peer learning and exchange as they develop and implement strategic approaches for increasing utilization of the program. Emphasis is placed on cross-system collaboration among city agencies, school districts and local anti-hunger groups.
Health and Human Services: Interdependent and Inseparable

To solve the challenges of health care, including high costs and poor outcomes, we must understand the drivers of those costs and the reasons for less-than-stellar results. More than ever before, the problems associated with health care are inextricably interwoven with those of human services — including economic inequality, poverty, mental health and substance abuse. If governments are to solve the challenges related to health care, they must also address the problems of human services — and vice versa.

When Poverty Means Poor Health — and Poor Health Means Poverty

In most of America, your ZIP code says a lot about you. There’s the obvious geographic location of your residence — East Coast, West Coast or Midwest — and whether you live in a rural or urban area. However, ZIP codes increasingly also tend to say something about your wealth (or lack thereof), the likelihood you are overweight, the probability of you having illnesses such as diabetes or heart disease, and your chances of living a long life.

If it sounds depressing, that’s because it is. People and families with low or no incomes are not just poorer, they’re in poorer health, as evidenced by the Robert Wood Johnson Foundation’s (RWJF) annual County Health & Roadmaps report. The 2014 report found Americans are living longer and healthier lives in general, but large gaps exist between the least healthy and healthiest places. The least healthy counties have twice as many children living in poverty, with higher unemployment rates, too many people paying more than they can afford for...
The linkage between health and wealth is even more prominent when looking at homelessness. “The experience of homelessness exacerbates chronic health conditions people already have,” says Richard Cho, deputy director at USICH. “In other cases, the complex health needs some people have will put them further at risk, or make their homelessness more persistent.”

The Role of Mental Illness and Substance Abuse in Health Care

Each year, nearly 1 in 5 American adults experiences a diagnosable mental illness, and 4 percent of Americans — approximately 9.6 million people — live with a “serious” mental illness, which impedes their ability to perform day-to-day activities such as going to work. For those diagnosed with a mental illness, this can be a vicious cycle of despair. Mental illness — particularly serious mental illness — can lead to job loss, which leads to poverty or homelessness.

People with mental health challenges also struggle with physical
health issues at alarmingly higher rates than the rest of the population. For example, individuals living with depression have a 67 percent increased mortality rate from cardiovascular disease and a 50 percent increased mortality rate from cancer. People diagnosed with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely because of physical health problems such as cardiovascular disease, respiratory disease and infectious disease.35

Substance abuse may also be part of the equation. Studies have found people diagnosed with mood or anxiety disorders are about twice as likely as the general population to also struggle with substance abuse, often in an effort to self-medicate.36

Lack of preventive attention to mental illness and poorly planned policies increasingly land people struggling with mental health or substance abuse in jails, emergency rooms or on the streets — all of which can come with exorbitant costs in the short or long term. Often, these individuals don’t receive any care for their core problem. According to the 2012 National Survey on Drug Use and Health, close to 8.4 million adults in the United States have both a mental illness and substance abuse disorder, but only 7.9 percent of those individuals receive treatment for both conditions and 53.7 percent receive no treatment at all.37 And only 62.9 percent of adults nationwide diagnosed with a serious mental illness received mental health treatment in the year they reported their illness.38

**Efforts to integrate health and human services are:**

- **Strongly agree**
  - Vital to solving problems in both areas, as there are strong interconnections between the two: 52%
  - Only possible if we have significant changes: 32%
  - Only possible if we have significant technology investments: 35%

- **Somewhat agree**
  - 40%
  - 45%

- **Neither agree or disagree**
  - 4%
  - 15%
  - 14%

- **Somewhat disagree**
  - 2%
  - 5%
  - 6%

- **Strongly disagree**
  - 1%
  - 2%
  - 2%

- **Don’t know**
  - 1%
  - 1%
  - 1%

Source: Governing Institute HHS Survey, 2015
Durham Connects provides free in-home nurse visits to all parents of newborns to improve the health and well-being of infants born in Durham County, N.C.
Smarter Policies and Programs for Better Results

Looking at Individuals and Families Holistically

Problems never occur in a vacuum. But the way government has traditionally approached solving problems is through programs that address one issue at a time without regard for the complex challenges a family or individual might be facing.

“Families experiencing homelessness often are connected to many different services,” says USICH Deputy Director Cho. “The challenge is these agencies to know a family well enough to say, ‘Wait a minute. That family is also struggling with housing or they are in a domestic violence situation where the mom is going to have to leave and she may become homeless.’”

Donald, who has all D.C. human services agencies under her purview, says the district is working on a model for integrated case management for families who are involved in the homeless system, the department of mental health and child welfare.

And Cho says USICH is working to provide communities with tools to bring services around the table. “USICH is focused on implementing coordinated entry systems in communities across the country. For example, there’s a model known as the system of care that’s been used for children with behavioral health challenges and for families with high needs that we are trying to replicate in communities addressing family homelessness,” says Cho. “In this case, you would bring all of the case managers a family has around the table and say, ‘We need to come up with a shared plan that addresses all of the family’s needs and their full set of challenges.’”

Addressing individuals and families holistically goes beyond helping the homeless. In North Carolina, the Durham Connects program is focused on understanding diverse family needs to improve the health and well-being of infants born in Durham County. The program provides free in-home nurse visits to all parents of newborns in the county.

“Families can be struggling with issues ranging from financial instability to mental health to problems with breastfeeding,” says Dr. Kenneth Dodge, founder of Durham Connects and the director of the Center for Child and Family Policy at Duke University. “We assess the family’s individualized needs and develop a profile so we can connect them to the community to meet those needs. They might need help finding the best child care agency. Or they might need to be referred to a mental health center for treatment of substance abuse. Whatever the issue might be, it’s all about connections — connecting with a family to help them connect to a community so they can connect with their baby.”

Prevention Pays Off

Prevention is often pursued as a holy grail for people who want to move the needle on reducing health care costs — not having a problem to begin with is the cheapest way to solve it.
Examples of successful prevention are easy to find. Prenatal care has long been touted as a way to lower risk of complications and improve the infant and maternal mortality rates. Immunizations have dramatically reduced or eradicated diseases such as polio, hepatitis B, measles and tuberculosis, among others. Even something as simple as adding fluoride to the public water supply has prevented cavities and tooth decay, which would have created costly interventions.

In an effort to bend the cost curve, there is increased interest in strategies and programs aimed at averting health issues. At the national level, the Centers for Disease Control and Prevention’s (CDC) National Center for Chronic Disease Prevention and Health Promotion works to prevent and control chronic diseases such as diabetes, cancer, heart disease, stroke and lung disease. The Center notes chronic diseases are responsible for 7 out of 10 deaths among Americans each year, and they account for 86 percent of U.S. health care costs.20 As part of its mission to improve the nation’s health by preventing chronic diseases and their risk factors, the Center helps support states’ implementation of public health programs, conducts public health surveillance, and develops tools and resources for stakeholders at all levels.

Local entities, too, are launching programs with a preventive focus, such as San Diego County’s lauded Live Well San Diego program (www.LiveWellSD.org). As one example of the sheer success of Live Well, the county hosted its fourth annual Love Your Heart event in February 2015 to encourage county residents to check their blood pressure as a way to prevent or detect heart disease or stroke.

“We had 88 sites across the county and in an 8-hour period we conducted 20,434 blood pressure screenings,” says Nick Macchione, director of San Diego County’s Health and Human Services Agency.

The county established a national achievement, but more importantly the event saved lives. “What was really stunning is one out of every two people reported an elevated blood pressure level,” Macchione says. “We had 80 people with urgent hypertension issues who were sent to the emergency room for immediate attention.”

Macchione says the event highlights the importance of prevention. “The people we treated needed immediate attention. But there are thousands of others who have diseases that can be prevented or controlled before they create a huge cost to society, and, more importantly, a huge cost to themselves and their families.”41

Preventive measures also have a place in addressing homelessness, says Donald of the Department of Human Services in Washington, D.C. “In the past, the focus on prevention has occurred when families come to the front door of the services center to get processed for eligibility into the shelter system. It’s been more of a diversion focus. My goal is to focus on upstream prevention.”

Donald points to her work in child welfare agencies and success in reducing the number of children placed in foster care by identifying — and addressing — the drivers. “People don’t wake up one day and decide they want to be homeless,” she says. “There are many opportunities for early alerts to identify what is going on in the life of a family where we can intervene earlier to stabilize them.”

The district is increasing funding to support its human services programs — including nearly $30 million in additional funding in the 2016 budget as well as a $100 million Housing Production Trust Fund that will help build and develop affordable housing for the future.
However, despite these benefits, preventive programs and policies around both health and human services can sometimes be a tough sell. Dodge of Durham Connects explains: “We’re paying way too much for tertiary care, rehabilitation and remediation. These are very expensive after-the-fact types of services. If we were to start over, we could spend the same amount of money — or less — in preventive services that would yield better outcomes. The problem is it might take a double payment for a period of time to get there.”

— Dr. Kenneth Dodge, Director, Center for Child and Family Policy, Duke University

Coordinating Programs and Funding Efforts

Many government leaders know collaboration and coordination are critical to better results and greater efficiencies, but what works in theory is often difficult to accomplish in reality.

Government has operated for decades with departments dedicated to solving specific challenges. Those departments also have separate funding streams and budgets — often tied to specific programs — and siloed data and systems. Staff shortages mean agencies must focus on their own objectives — there is little time to consider how they might have a role in helping another department or agency realize theirs.

Still, even with these constraints, things are changing. As the focus on integrating health and human services intensifies, so too does the attention on how other programs and agencies can be better, together. For example, USICH Executive Director Doherty says successful communities make sure they don’t have a standalone system for planning how to address homelessness.

“We’re paying way too much for tertiary care, rehabilitation and remediation. If we were to start over, we could spend the same amount of money — or less — in preventive services that would yield better outcomes. The problem is it might take a double payment for a period of time to get there.”

— Dr. Kenneth Dodge, Director, Center for Child and Family Policy, Duke University

Mainstream programs, including county or city HHS programs, housing agencies and employment agencies, need to be part of the planning process and look for how to align HUD-funded programs in conjunction with resources such as Temporary Assistance for Needy Families (TANF), Medicaid and Social Security benefits,” Doherty says. “They need to coordinate how they are administered on a day-to-day basis so it becomes a systematic use of a broad range of resources to respond to the crisis of homelessness.”

Doherty says agencies also stand to gain from collaborative funding models. “We are seeing more communities at the local level bring together local philanthropic organizations and public agencies to think through how to partner their resources to be more efficient and access the kinds of support they need to deliver strong programs in support of ending homelessness.”

This could include health care funds, housing dollars and philanthropy, among other resources. “Sometimes these agencies issue a joint notice of funding availability (NOFA) for how the funds will be awarded to agencies so they can put together the full range of resources and identify how they will strengthen their programs or expand services available in their community,” says Doherty.

Cities approaching funding in this way include Houston and Los Angeles. Following are some examples of their success:

• Houston has decreased homelessness by 37% since 2011. Los Angeles is on track to end veteran homelessness by 2016.

• Houston has decreased homelessness by 37% since 2011. Los Angeles is on track to end veteran homelessness by 2016.
For example, Indiana used data and analytics to determine that the state’s youngest mothers on Medicaid (ages 15 to 20), who are not getting the recommended number of prenatal visits, comprised 1.6 percent of all births but accounted for nearly 50 percent of all infant deaths. Additionally, nearly 65 percent of infant deaths were to mothers with 10 or fewer prenatal visits. The state found infants born to the highest-risk mothers comprised 5 percent of all Medicaid births, but they accounted for 35 percent of its birth-related expenses.

Armed with this data, Indiana is encouraging women to attend all of their prenatal visits, but is also investigating the reasons why women don’t go in the first place. One of the primary reasons is lack of transportation — the mother simply did not have a way to get to the appointment — so the state is finding ways to connect expecting mothers with

In Missouri, the Department of Health and Senior Services has a data-sharing project with the state’s departments of Mental Health and Social Services. The project includes the implementation of an online portal that can be accessed using Missouri’s health information exchange (HIE). Within the portal, data can be shared with primary care physicians and community mental health facilities, which often treat patients with severe chronic conditions. Under the strategy, hospital use is down by 20 percent and emergency room visits fell by 12 percent among Medicaid enrollees. The drop in emergency room visits alone will save the state $8 million annually.44

But state and local governments are also using data to predict problems. Using data, states can intervene before issues occur and be better prepared for challenges as they arise.

The Missouri Department of Health and Senior Services’ data-sharing project with the state’s departments of Mental Health and Social Services resulted in a 12 percent decrease in emergency room visits among Medicaid enrollees — saving the state $8 million annually.
transportation options. It’s another example of the interconnectedness of human services and health care.

Insurance companies are also using data to reduce the number of preventable hospital readmissions by predicting which patients are likely to be hospitalized within three months. They are able to make this prediction based on algorithms of huge amounts of health data, including billing claims, lab readings, medications, height, weight, family history and the client’s neighborhood. Once a high-risk individual is identified, the insurance company assigns a “health coach” and a coordinated effort ensues to provide the patient with health information, make medical appointments, resolve medication issues or arrange transportation. With this method, insurance companies have already realized a 40 to 50 percent reduction in expected hospital admission rates for congestive heart failure patients.

Human services agencies, too, can greatly benefit from this technology. Data and analytics provide agencies with greater insight into their customer base. Much like private corporations mining Internet data or using geospatial mapping to target advertising, agencies can leverage data to customize the design and delivery of services. In this way, governments can move away from the flawed one-size-fits-all approach that has traditionally dominated social services programs.

For example, agencies can use data to map hotspots for child abuse and neglect, which enables child welfare employees to investigate what is driving these cases of abuse and focus resources and preventive measures in specific neighborhoods.

In Washington state, the Department of Social and Health Services’ integrated client database provides a comprehensive view of the life experiences of residents and families who are part of the social services system. The database allows the state to move away from simply processing transactions and take a proactive approach. Washington uses data to understand which early interventions make the most difference and which services can best help each client.

Similarly, NYC’s Department of Homeless Services (NYC-DHS) is using a Web-based application to aggregate data from multiple sources and present it in a map-based view. The application allows NYC-DHS to divert resources to transportation options. It’s another example of the interconnectedness of human services and health care.

When asked if the use of analytics is critical to lowering health care costs and improving outcomes, HHS leaders:

| Strongly agreed | 41% |
| Somewhat agreed | 41% |
| Neither agreed nor disagreed | 12% |
| Somewhat disagreed | 2% |
| Strongly disagreed | 1% |
| Didn’t know | 3% |

Source: Governing Institute HHS Survey, 2015

Improving Data Management

Siloed departments and systems have made it challenging for agencies to share data to gain insights, but additional problems occur when data is collected, managed and stored across disparate systems — it’s often inconsistent and contains duplications, errors and incomplete entries.

These discrepancies in citizen records and data impact agencies and programs across the enterprise, including HIXs, Medicaid, unemployment and other benefits. The lack of a consistent citizen record can create flawed and inefficient service
delivery, opportunities for fraud and missed chances to collaborate on decision-making.

One solution to this is master data management technologies, which allow organizations to create master records from existing data while preserving agency investments in individual applications. Master data management technology manages data regardless of its source, format or application and can develop common data governance and life cycle rules across the enterprise. By creating a master data record of citizens across the government enterprise, agencies can gain a holistic view of citizens or program recipients for better, more integrated service delivery.

Government can also reduce fraud as multiple HHS agencies can more accurately determine eligibility, eliminate duplicate transactions and fraudulent claims, and decrease the amount of improper payments.

Finally, consistent data records can provide a foundation for research and analysis to address key policy questions and identify and develop more effective initiatives and programs. For example, public health, health care and transportation departments can use data from multiple organizations to more accurately identify geographic and demographic trends, forecast problems, allocate resources more appropriately and model scenarios for better planning.49

**Reducing Waste and Identifying Fraud**

As state and local governments wrestle with questions of financial sustainability, the elephant in the room is often fraud. In March 2015, the Health Care Fraud and Abuse Control Program (HCFAC) announced its prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in FY 2014 from companies and individuals who had attempted to defraud federal health programs. HCFAC noted that for every dollar spent on health care-related fraud and abuse investigations in the last 3 years, the administration recovered $7.70.50 Fraud is a multifaceted problem in HHS. Not only do successful fraud attempts siphon money away from legitimate beneficiaries, it’s also traditionally costly for government agencies to ferret out illegal activity. Persistent, manual investigation is often needed.

However, data and analytics technology is making it easier for agencies to efficiently identify possible fraudulent activity. Two of the largest targets for fraud reduction are Medicare and Medicaid. With urging from CMS, forward-thinking states are moving away from the pay-and-chase model — also known as retrospective recovery — to a cost avoidance strategy. The pay-and-chase approach is problematic because it can be time consuming and labor intensive — often involving audits of paper records and files — and can be prolonged by provider appeals.

By applying predictive analytics to data about claims and providers, Medicaid agencies can prevent improper payments. The state of Iowa is a leader in Medicaid fraud prevention and reduction and has applied predictive

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**When asked if analytics is critical to identifying fraud in health and human services, HHS leaders:**

<table>
<thead>
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<th>Perception</th>
<th>Percentage</th>
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<tr>
<td>Strongly disagreed</td>
<td>0%</td>
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<tr>
<td>Didn’t know</td>
<td>4%</td>
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Source: Governing Institute HHS Survey, 2015
analytics across the entire Medicaid claims process since 2011. For every dollar Iowa spends in its Medicaid program integrity initiative, it earns $7.50. In 4 years, the state saved nearly $129 million, with approximately 40 percent of the savings attributed to cost avoidance activities.  

Iowa Workforce Development (IWD) is also utilizing sophisticated big data analytics in the cloud to target fraudulent unemployment compensation claims. IWD’s caseload is high — in 2013 it processed 190,000 claims, paying out approximately $432 million in benefits in 2012 and 2013. The new initiative, which began in March 2014, uses publicly available data sets in conjunction with IWD data to generate potential fraud leads. The software used by IWD analyzes incoming claims using predictive modeling, data mining and matching, and geospatial and search engine technologies to investigate and prevent potential fraud before it occurs.

**Integrated Eligibility Systems**

In the last several years, states have renewed their focus on integrated eligibility systems and the elusive “no wrong door.” In preparation for ACA enrollment, many states took advantage of CMS’ 90/10 matching funds — in which the federal government provided 90 percent of the funding for Medicaid eligibility system upgrades. Nineteen states have issued contracts for upgrades to Medicaid eligibility and enrollment systems since 2012.

This focus will continue as CMS has proposed extending the 90/10 funding rule indefinitely (it was previously set to expire in December 2015). As part of the rule, CMS also provides up to 75 percent of the funding for ongoing maintenance and operations of these systems. Additionally, the Office of Management and Budget (OMB) extended the Circular A-87 waiver through December 2018, which will continue to support the integration of eligibility systems among HHS programs such as SNAP and TANF.

Upgrading Medicaid eligibility systems provides states with opportunities to integrate eligibility for human services into these systems as well. By doing this, HHS agencies can better collaborate through shared data, reduce redundancies and provide faster, streamlined services to benefit recipients.

When it comes to integrated eligibility systems, Ohio is a standout, receiving the National Association of State Chief Information Officer’s (NASCIO) 2014 State IT Recognition Award for cross-boundary collaboration. Initiated in April 2013 and completed in October 2013, Ohio’s modernization project was the fastest eligibility system upgrade in the nation. The initial lift was to streamline Medicaid eligibility by facilitating real-time eligibility determination and providing a real-time interface with the state’s MMIS.

In 2015, the state began expanding the solution to support human services such as TANF, SNAP and other income-driven eligibility programs.

**Document and Case Management Systems**

As the focus on integrating health and human services and implementing integrated eligibility systems has heightened, so too has the emphasis on reducing silos among disparate human services agencies through enterprise-wide case management systems.

Case management systems have increasingly moved from document-centric solutions that simply house paperwork to client-focused platforms that provide a more complete picture of an individual or family. They have also increased in sophistication, featuring automated tools to increase the productivity of frontline caseworkers, allowing them to focus on improving the lives of those they serve rather than manually inputting what was often redundant information.

For example, one place an integrated case management system can be critical is in child welfare agencies, where lack of information can have negative or even tragic consequences for our nation’s most vulnerable citizens. Case management systems can be used to house and organize data about a child from sources both inside and outside the government, giving caseworkers a clearer shared understanding of what is happening with that child. Information about emergency room and doctor visits; TANF, SNAP
By offering robust websites and apps, HHS agencies empower social services beneficiaries with real-time information about their accounts. For example, SNAP participants can access their balance at the grocery store and know exactly how much money they have to spend. With mobile solutions, citizens can access services in the most streamlined and efficient way possible.

Mobile devices — particularly those that have been hardened or made rugged for work outside of the office — can also dramatically increase the productivity of social services caseworkers who predominantly spend their time in the field. Trips to and from the office to input information become unnecessary and allow ever-burdened social services agencies to do more with less.

If any entity understands the need to do more with less, it’s Los Angeles County’s Department of Public Social Services (DPSS). The agency has a caseload larger than any other jurisdiction other than the states of California and New York, and its annual budget exceeds $3 billion. To keep pace with growing caseloads, the agency made more services available through alternative means, including over the telephone, through Web portals, and via mobile devices and corresponding mobile applications. DPSS built an enterprise electronic document management system putting its 3 million-plus cases online, allowing caseworkers to share information more effectively.

The agency also has a robust informational website and an interactive portal called “YourBenefitsNow!”

HHS agencies are serving citizens through mobile applications — including resources for everything from prenatal care to elder care. As of April 2015, NASCIO cataloged 350 state and local government apps — many of them are HHS apps.

Websites, Mobile Devices and Apps

On USA.gov, there is a running list of apps provided by government agencies. The CDC has 14 apps. CMS has four. The Department of Health and Human Services has 13. NASCIO also maintains an online catalog of state government apps. The current total as of April 2015 was 350. This doesn’t include apps built and maintained by city and county governments.

All of this is a testament to the rise of mobility in government. Mobile solutions are a good bet for government agencies because they are popular with the public, and while they don’t cost much to implement (an app can be built for a couple hundred to a couple thousand dollars), the agency can quickly see savings, particularly in increased productivity.

This is especially true for HHS agencies, which typically serve populations more likely to depend on their phone for Internet access. According to a Pew Research Center study, 13 percent of Americans with an annual household income of less than $30,000 per year are smartphone dependent.

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or other benefits the child’s family receives; missed school days and more can all help caseworkers make connections and spot potential problems.

Boulder County, Colo., implemented an integrated case management system when it merged its housing and social services agencies, creating the unified Department of Housing and Human Services. The system provides caseworkers with a comprehensive view of each client’s situation and helps identify opportunities to apply early intervention with access to wrap-around services. Through the system, caseworkers can more closely track clients’ progress. Boulder County expanded the number of residents receiving services by 140 percent, mostly by focusing on front-end and early intervention.
Telemedicine

Since telemedicine was first introduced in the 1980s, the number of patients seen using this technology has increased from a few thousand to more than 10 million. Telemedicine's initial promise was in providing medical services to individuals who had barriers to access. This largely included rural areas with a shortage of primary care physicians. Telemedicine was also used to connect primary care doctors in remote areas with specialists who were based out of larger cities with sophisticated medical and research centers.

Telemedicine then became widely deployed in prisons as a way to provide care and consultations for individuals who were incarcerated without incurring the costs or safety issues associated with transporting them to a physician's office. But now states are recognizing telemedicine's benefits in a variety of ways.

Some states are using telemedicine to address costly chronic diseases, particularly in areas with little access to health professionals. In Mississippi, the Diabetes Telehealth Network is providing people with diabetes more consistent and timely access to clinicians through the use of telehealth technology in their homes. Mississippi has the second-highest rate of diabetes in the nation, with more than 12 percent of adults in the Mississippi Delta — one of the most underserved and impoverished regions in the nation — diagnosed with Type 2 diabetes. Medical expenses in Mississippi related to diabetes totaled more than $2.7 billion in 2012.

Other states are using telemedicine to improve outcomes and prevent costly hospital readmissions. On the west coast, Oregon Health and Sciences University (OHSU) uses a device to connect with discharged congestive heart failure patients. The device can operate through a phone line or cable connection and requires patients to enter their weight, heart rate and blood pressure each day. OHSU receives alerts regarding patient data, which are then shared with the individual's primary care physician. The system is showing promise — less than 20 percent of patients using the device were hospitalized within 30 days compared with a national average of 24.7 percent.

However, even given these advances, hurdles remain for telemedicine, including cross-state licensure issues, insurance reimbursement for services and broadband connectivity. In many cases, state regulations haven't kept pace with technology. But the benefits of substantially improved access — particularly to individuals in rural and remote areas — make it important for governments to address and overcome these challenges.

State governments are making progress. In more than 40 states, Medicaid now covers telehealth and in 22 states, telehealth visits are required to be reimbursed at the same rate as in-person visits.
Exceptional Care and Improved Services at an Affordable Price

How do governments provide effective, comprehensive care and services in a way that is fiscally sustainable? That was the question posed in the beginning of this report and the challenge leaders at every level are grappling with every day. There are no easy answers, but pieces of the puzzle are falling into place. The biggest piece is the integration of health and human services — through policy, practice and technology implementations. But as one astute practitioner interviewed for this report observed: That’s a very easy thing to say and a much harder thing to do.

Five years after the ACA passed, most people would agree that chaos no longer reigns. But the goal of the ACA was not to simply give more people access to a broken system — it was to improve the system and the health of our country as a whole. As governments move forward from HIX implementations, they will strive toward new goals in more efficiently delivering better care and services in the most cost-effective way.

Increasingly, the future includes Medicaid payment reform, as well as models that provide incentives for value over volume. It also includes policy changes that allow agencies to collaborate and share data to serve citizens in a way that recognizes they are complex beings and families with needs that almost always span multiple departmental silos.

What is clear is government leaders are up to the challenge and, as this report shows, there are pockets of innovation everywhere with people who are finding processes and programs that work.
Treatment approaches, the amount of care provided and total cost to patients for a specific illness can vary widely by doctor and hospital. In the wake of the Affordable Care Act, the state of Arkansas believed narrowing these differences within its Medicaid program — and offering doctors incentives to do so — could help reduce costs, provide better care and potentially revolutionize health care delivery.

To aid the state’s efforts, General Dynamics Health Solutions (GDHS) crafted an advanced analytics solution to collect clinical and quality data from doctors and hospitals, and then share the results and related best practices with those providers. Using the Quality Care Insight tool, providers can now learn how their peers address specific health concerns, such as congestive heart failure or cancer, and related treatments, costs and outcomes. Using the GDHS Quality Care Insight tool, Arkansas providers have fine-tuned their treatments to improve patient outcomes, drive down costs and share in the savings.

Propelling Results

With its ability to integrate clinical, quality and administrative data for a holistic view of patients, Quality Care Insight is aiding Arkansas to transform health care from fee-for-service to value-based rewards. Results include:

• Reduced antibiotics use for unspecified upper respiratory infections by 23.5 percent
• Improved screening of pregnant women for chlamydia by 9.3 percent, and decreased the C-section rate by 7.4 percent
• Improved conditions for heart failure patients by reducing readmissions by 6.1 percent and decreasing 30-day outpatient observation care by 7.9 percent
• Reduced Medicaid costs resulting in a savings of about $720 million since July 2012

The Quality Care Insight helps agencies and providers connect the dots between individual patients, health care services and overall population health. This integration of data can lead to improved outcomes and significant cost savings.
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Q&A: Adobe

Leveraging Technology for Improved Services & Efficiencies
The OMB Circular A-87 Cost Allocation Exception Helps Streamline Integrated Eligibility

As a long-time public servant, most recently serving as the CIO for the Ohio Department of Job and Family Services, Kumar Rachuri provides his perspective on how states can leverage Adobe solutions and the Office of Management and Budget (OMB) Circular A-87 cost allocation exception to improve services, drive policy change and lower operating costs.

Q: What is OMB Circular A-87?
The OMB Circular A-87 establishes principles and standards to provide a uniform approach for determining costs and to promote effective program delivery, efficiency and better relationships between governmental units and the federal government.

Kumar Rachuri: OMB Circular A-87 is the result of federal agencies recognizing that integration and interoperability of HHS eligibility systems are key to improving citizen services and increasing efficiencies. Before OMB Circular A-87, states weren’t able to leverage hardware across program areas, so even though one program may have had hardware functioning at 10 to 20 percent efficiency and 80 to 90 percent of that hardware was available, it could not be used for another program area. The beauty of OMB Circular A-87 is it gives state governments an opportunity to wipe out those demarcations between the program areas and the supporting technology. Now, states can use the funding to build one eligibility system that spans nutrition services, Medicaid, family and children services, child welfare and other HHS programs.

Q: Why is this important to state HHS departments?
Kumar Rachuri: OMB Circular A-87 allows funding to go a lot further. States are now able to receive a 90/10 match toward the design, development and implementation of an eligibility system — the federal government will fund 90 percent of the project and the state covers the remaining 10 percent. And since data from various program areas can be housed under one umbrella, it can be more easily analyzed and used to facilitate healthier citizen outcomes and drive policy changes. It’s a very attractive proposition for states — helping them to make data-driven policy decisions, improve outcomes and lower expenses.

Q: How can states leverage Adobe technologies through the OMB Circular A-87 cost allocation exception?
Kumar Rachuri: The federal government has identified several elements that need to be included in state eligibility systems, including “front door” technologies such as document systems, client portals, workflow management solutions and customer service systems. Adobe technology offerings can help meet these requirements. For example, the Adobe Experience Manager is a platform-based solution that enables states to build self-service portals for citizens. It has five modules that can be purchased together or individually, including Web and content management, digital asset management, social communities, forms and documents, and customer-facing mobile apps. The Adobe Experience Manager technology stack can provide responsive and adaptive front-end operations in HTML5 and a workflow management engine in the back end to enhance the efficiencies of large-scale centralized case management systems.

With Adobe, the program eligibility life cycle can be completely digital, including signatures with the Adobe Document Cloud eSign service. With the OMB Circular A-87 cost allocation exception and Adobe solutions, states can streamline eligibility systems and HHS services while reducing operating expenses and improving the quality of service delivery to constituents. Implementation of these technologies has helped several states reduce operating costs by millions of dollars while trimming workflow process times from weeks to minutes.

Adobe transforms public sector customer experiences with digital capabilities that improve engagement, cut costs and make government more efficient. Adobe’s solutions enable organizations to create and deliver content in a way that citizens, warfighters and employees have come to expect. Adobe provides the public sector with tools to digitize services and measure its impact while securing mission-critical content across all devices.

To learn more about Adobe Government Solutions, visit adobe.com/government or call us at 1-800-87ADOBE.
BETTER DATA COORDINATION CREATES BETTER SERVICE DELIVERY

It’s Always Been Difficult to Work Together
From administering healthcare and child welfare programs to providing employment training and legal assistance – health and human services (HHS) agencies are hard-pressed to meet the growing needs of their communities. Keeping up with regulatory changes is tough enough, but the agencies need to ensure that decisions made will produce cost containments and the delivery of better services to the public.

Despite outward appearances, agency insiders know how challenging it is to effectively coordinate services when crucial data is often difficult to access and interpret within context of the individual recipient and the law. Ultimately, disjointed operations and lack of insights force HHS agencies to say “no” more often than not to requests for faster turnaround of eligibility verification and expedited coordination of benefits.

But It’s About to Get a Whole Lot Easier
Today, MarkLogic is changing all that. Our agile, powerful and secure Enterprise NoSQL database empowers HHS organizations to turn “no” into “now.” Deployed as a data services hub capable of integrating any type of data across disparate silos, systems and formats – MarkLogic equips agencies to deliver efficient, cost-effective services to the community. With a unified point of access and smart analytics platform, HHS employees spend less time hunting down elusive information and have more time to focus on improving service and fulfilling the critical missions of their agencies.

MarkLogic® Enterprise NoSQL Platform Supports Your Mission
• Build apps faster with flexible information architecture and data models
• Integrate and analyze information from multiple sources and formats
• Quickly find and deliver information anytime, any place, over any channel
• Advance interoperability, HIE and care coordination
• Secure, share and manage information
• Build a 360-degree view of client communities
• Streamline operational processes to contain costs

MarkLogic empowers agencies to integrate and operationalize data from across departments and systems for faster, well-informed decision-making. Let’s rethink what’s possible for HHS organizations and their growing client communities. You aim to better serve the community. We make it easier for you to do so.

To learn more about MarkLogic solutions, visit us at www.marklogic.com/solutions
Data breaches abound in the digital world, and few are harder hit by these attacks than health care companies and their customers. This comes as no surprise — the information used in health care transactions, including names, addresses, employment information, Social Security numbers and more, is some of the most sought — after data by cyber thieves. As more health-related data and personally identifiable information move to a digital format, it is imperative health care companies shore up security measures to maintain consumer trust. Aetna realizes this and utilizes several strategies to secure data while also leveraging shared information for further protection.

In a recent report, Aetna was identified as the only health care company receiving a passing grade in security. In fact, it scored a perfect 100 for email security protocols. It’s the only health care company in the world that uses the DMARC standard, which means emails are checked against a record on company servers and a notification is sent to the company warning of any spoofed, malicious or suspicious emails.1

This strategy, combined with other security technologies, decreases spam to consumers, results in fewer phishing attempts and ultimately better the member experience.

“What Aetna is doing is protecting all members and consumers from receiving fraudulent email, some of which is phishing attempts,” said Jim Routh, Aetna’s chief information security officer. “In our case, 60 million fraudulent emails are not going to be delivered to consumers or members this year because of DMARC.”2

As a leader in the application of cybersecurity controls, Aetna participates in the exchange of best practices with national coalitions and companies in the data intelligence community to learn from each other and become better prepared to handle threats. Aetna follows the technical details of every reported breach to look for opportunities to improve its security measures. While hackers and data thieves exchange information to get a leg up on health care companies — Aetna is doing the same to expose bad actors and help prevent breaches from occurring.

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2. Ibid.
Making Medicaid Transformation a Reality

Value-based purchasing delivers better quality of care, improves outcomes and reduces costs

Despite the fact the United States spends more per capita on healthcare than any other industrialized nation, it consistently ranks last or near last in terms of quality and outcomes compared to health systems in other Western countries. Given the combination of both increased opportunities and cost pressures created by the Affordable Care Act, state Medicaid programs are often leading the way to change the direction of healthcare by reducing costs and improving outcomes for beneficiaries.

Real transformation is achieved when providers are paid for successful outcomes instead of services performed — paying for value rather than volume. Through its Government Healthcare Transformation (GHT) practice, KPMG is spearheading this value-based purchasing approach within Medicaid. Using a state’s own data, KPMG’s GHT practice builds upon a population-focused analytical approach that helps state Medicaid programs reimagine the way they operate, deliver and pay for services, by providing:

- Rapid access to a fully interactive, customizable, dynamic interface to explore the total costs and outcomes of care delivered in Medicaid based on population, health condition, geography or provider
- Insight to where value is being created and leaked out of the system (e.g., high costs and poor outcomes due to fragmentation, inadequate delivery infrastructure, etc.)

- Rapid access to complementary data sources for multi-payer analyses where a more comprehensive analysis is required
- Insight into how managed care organizations deliver the most value and where opportunities lie for improvement
- Built-in capabilities to support value-based payment initiatives, including bundled payments as well as total cost of care (capitation) arrangements
- Robust experience in linking insights to action, tailored to the specific challenges that vary significantly per state
- In-depth experience in supporting delivery and payment reform initiatives driven by states

New York, which engaged KPMG to support its delivery and payment reform programs, is a front runner in Medicaid payment reform. Care for almost 6 million beneficiaries will be contracted through value-based arrangements within 5 years. In parallel, the state is targeting a 25 percent reduction in avoidable hospital use through a combination of performance payments and shared savings opportunities.

Through its GHT practice, KPMG is uniquely positioned to help states achieve these results. KPMG has the expertise and the toolsets to make Medicaid transformation a reality.

To learn more, visit: www.kpmg.com/us/hhs
Treatment approaches, the amount of care provided and total cost to patients for a specific illness can vary widely by doctor and hospital. In the wake of the Affordable Care Act, the state of Arkansas believed narrowing these differences within its Medicaid program — and offering doctors incentives to do so — could help reduce costs, provide better care and potentially revolutionize health care delivery.

To aid the state’s efforts, General Dynamics Health Solutions crafted an advanced analytics solution, Quality Care Insight, to collect clinical and quality data from doctors and hospitals, and then share the results and related best practices with those providers. Using the Quality Care Insight tool, providers can learn how they and their peers address specific health concerns, such as congestive heart failure or hip replacement surgery, and related treatments, costs and outcomes. Using the General Dynamics Health Solutions Quality Care Insight tool, Arkansas providers fine-tuned their treatments to improve patient outcomes, drive down costs and achieve savings.

**Propelling Results**
With its ability to integrate clinical, quality and administrative data for a holistic view of patients, Quality Care Insight is helping Arkansas move from from a fee-for-service model to a value-based health care system. Results include:

- **Reduced Medicaid costs** resulting in a savings of approximately $720 million in the last three years
- **Reduced antibiotics** use for unspecified upper respiratory infections by 23.5 percent
- **Improved screening** of pregnant women for chlamydia by 9.3 percent, and decreased the C-section rate by 7.4 percent
- **Improved conditions for heart failure** patients by reducing readmissions by 6.1 percent and decreasing 30-day outpatient observation care by 7.9 percent

Quality Care Insight helps agencies and providers connect the dots between individual patients, health care services and overall population health. This integration of data has led to improved outcomes and significant cost savings throughout the Arkansas Medicaid Program.

**One-Stop Application: Quality Care Insight**
The General Dynamics Health Solutions Quality Care Insight solution acts as a one-stop application for health care data and services, including:

- Bundled payment calculations
- Analytics and dashboard reporting in real time
- Quality metrics for payers and provider systems
- Drill-down reporting, customizable to a user’s role or identity
- Content aggregated from multiple data sources
- Notifications and alerts via email and dashboards

To learn more, visit: www.gdit.com/health
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FDaaS, by Pondera Solutions, is the premier solution for combatting Fraud, Waste and Abuse in Government programs.
The ‘90s called, and they want their paper back.

Your current document management system isn’t working.

Why else would your caseworkers still be buried in all this paper and creating workarounds that generate even more paper? There are many reasons. Your system may not have been designed well in the first place. Maybe it isn’t up to date with current work processes or it hasn’t kept pace technologically. Whatever the reason, your current document management system is causing you to struggle to meet mandated requirements.

At the same time, you’re being asked to provide greater access to services, and your clients are expecting to get information how and when they want it. That means you want to provide clients all new options to interact and submit documents with things like smart phone apps and self-service portals that don’t require them to come into an office. This adds a whole new level of complexity to your document management challenges that wasn’t even fathomed when your current system was implemented.

As a result, clients are forced to continue waiting in the lobby to drop off documents. And caseworkers continue making paper copies because they can’t trust they’ll be able to find a document when they need it again.

Workers are frustrated. Clients are frustrated. Your system is broken.

Northwoods can help. Exclusively serving state and local human services agencies for over 12 years, we are your document management experts.
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Keeping business and IT in balance

Complex HHS programs require leadership across multiple departments and stakeholders, expert navigation of evolving requirements and regulations, and hands-on knowledge of the various capabilities of IT providers.

An independent Enterprise Program Management Office (EPMO) is a practice trending with a growing number of governments. Offering powerful support for agencies implementing programs that require complex stakeholder ecosystems, CGI’s independent EMPO provides extraordinary rigor around processes and communications to mitigate project risk and improve outcomes.
1. The ACA requires nearly everyone to have health insurance that meets minimum standards. With some exceptions, people who do not maintain health insurance coverage have to pay a penalty.


9. Ibid.


19. All quotes and information from an interview with Jessica Kahn conducted on June 30, 2015.


21. All quotes and information from an interview with Dr. William Golden conducted on July 16, 2015.


26. All quotes and information from an interview with Ester Fuchs conducted on June 18, 2015.


28. All quotes and information from an interview with Matthew Doherty and Richard Cho conducted on March 24, 2015.

29. All quotes and information from an interview with Brenda Donald conducted on June 11, 2015.


31. http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf411678


33. All quotes and information from an interview with Matthew Doherty and Richard Cho conducted on March 24, 2015.

34. http://www.newsweek.com/nearly-1-5-americans-suffer-mental-illness-each-year-230608


39. All quotes and information from an interview with Nick Macchione conducted on April 3, 2015.


51. https://dhs.iowa.gov/sites/default/files/IME_Saves_$49.5_Million_Last_Year.pdf


58. https://afd34ee8b0806295b5a7-9fbee7de86d75069107.ssl.cf1.rackcdn.com/CDG15_ANNUAL_TLP_V.pdf


