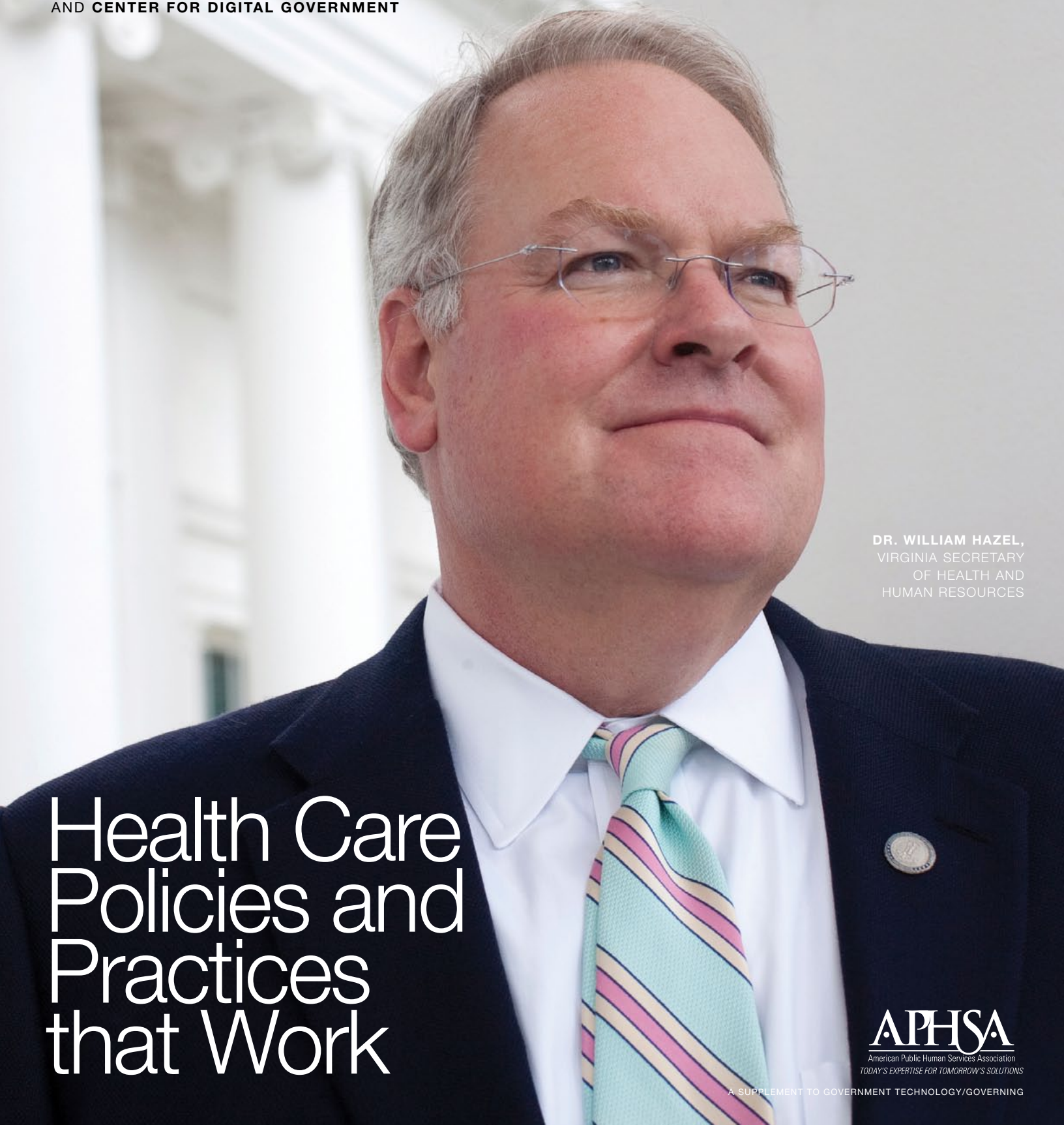
Health+Human Services Special Report

A RESEARCH REPORT FROM THE **GOVERNING INSTITUTE** AND **CENTER FOR DIGITAL GOVERNMENT**



DR. WILLIAM HAZEL, VIRGINIA SECRETARY OF HEALTH AND HUMAN RESOURCES

Health Care Policies and Practices that Work

APHSA
American Public Human Services Association
TODAY'S EXPERTISE FOR TOMORROW'S SOLUTIONS

A SUPPLEMENT TO GOVERNMENT TECHNOLOGY/GOVERNING

Innovative Identity Solutions Help **Prevent Fraud and Protect Public Funds**

Reducing the risk of benefits theft

In a time when social service agencies across the country must operate with tighter budgets and staff reductions, investigating claims by false applicants adds a needless layer of complexity in helping those who truly qualify — and no state in the U.S. has more identity theft than Florida.

Nearly 90 percent of the five million benefits applications received annually by Florida's Department of Children and Families (DCF) are now administered online. Web-based usage for programs such as SNAP or Medicaid saves time and effort for customers and DCF alike — but increased anonymity also heightens the organization's vulnerability to fraud.

Fighting fraud through the power of connections

To stop cheating at the "front door," DCF is piloting next-generation identity analytics from LexisNexis® Risk Solutions that gives the agency access to 10,000 data sources and 34 billion data records.

The solution's comprehensive logic utilizes LexisNexis' vast database records, meaningful case filters and knowledge-based questions to validate identity and benefits eligibility — or expose hidden assets or relationships that may rule them out, such as property and vehicle ownership, business affiliations and other identifiable records.

The technology assimilates seamlessly into agencies' existing work systems, summarizes results in an easily interpreted score, and enables swift, secure admittance to products, services and information to verified customers.

With an initial deployment in Florida's central region that resulted in triple the projected cost savings, a full-state rollout was completed in August 2013. In changing its fraud-fighting model, DCF hopes to save $60 million per year in preventable payouts.

Best-in-class solutions

Government agencies that incorporate big data and state-of-the-art identity analytics can be more successful in exposing costly benefits abuse. Best-in-class LexisNexis predictive analytics, fraud detection and identity management solutions can help keep critical public funds out of the hands of criminals — and into the hands of those who need them.

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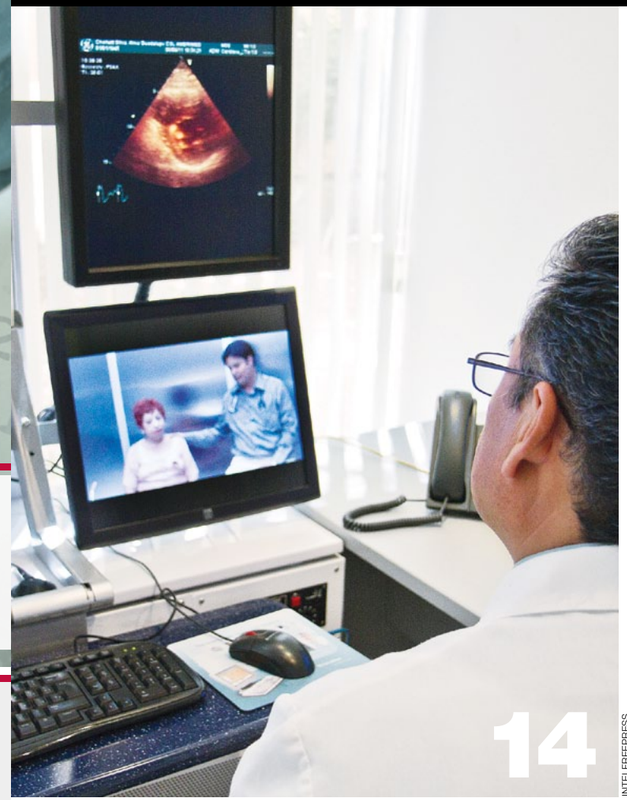

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e.Republic SMART MEDIA FOR PUBLIC SECTOR INNOVATION

COVER PHOTO BY DAVID KIDD

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Code Blue: The Heart of the Matter

It was an "Oh my god!" moment. That's how one of the more than two dozen people interviewed for this report described waking up on Nov. 7, 2012. The U.S. Supreme Court had upheld the Patient Protection and Affordable Care Act (ACA) the previous June, and now, with Barack Obama re-elected president, there was no way to avoid it any longer. The ACA was here to stay.

"Timelines became real, and people who had been sitting on their thumbs were faced with getting off their thumbs," that insider said. For many of those working in the health and human services (HHS) space, that was, in hospital terminology, like calling Code Blue: We've got an emergency on our hands.

With demand for services — already high due to fallout from the economic challenges of the past few years — now set to explode even more, and with both staff and budgets cut and stretched to near-breaking points, state and local HHS departments needed to implement all the requirements of the ACA in an aggressively short timeframe. There was "a sense of panic" throughout the space, both public and private sector interview subjects said. The ACA became everyone's top priority and consumed most departments' time and energy — especially those building their own health insurance exchanges — and often pushing other important initiatives not just to the back burner, but off the stove entirely. "We spend all day, every day preparing for the ACA," one HHS employee said.

With challenge, though, comes opportunity. The ACA has forced everyone to re-think what is possible in every corner of HHS operations. This confluence of increasing demand, scarcity of supply, unsustainable financial models and the sleep-depriving deadlines of ACA rollout has prompted a collaborative, innovative response that has often brought unlikely partners together to find new solutions, create new technologies and lay the groundwork for a better future.

Collaboration is often the key. By working together, whether it's among states and localities themselves or formerly disparate agencies within a single community, HHS leaders have crafted creative ways to address Medicaid reform; data sharing; eligibility integration; and fraud, waste and abuse reform. They have found ways to tackle the worrisome provider shortages the nation faces and implement prevention strategies to keep constituents healthier and lower the demand on services.

And they continue to update or replace outdated and outmoded technology with powerful new systems to meet the operational demands of the 21st century. It starts, of course, with the mandated health insurance exchanges, but has also branched out into data warehousing solutions, big data analytics, mobile adaptability and other solutions designed to help everyone work smarter and more efficiently.

> "Timelines became real, and people who had been sitting on their thumbs were faced with getting off their thumbs."

This Special Report highlights some of the best practices and most noteworthy solutions currently on the ground in the HHS sphere. The work is far from done, of course. Jan. 1, 2014, the date the ACA officially comes online, is right around the corner, and it will reveal kinks and glitches that will demand immediate and careful attention. Initiatives that were pushed aside in 2013 will insist on focus as well.

But those who work in HHS will soon find themselves in a new world, one in which the "Code Blue" has been mitigated and where the "patient" — public service — is recovering and on the road to an exciting future. +

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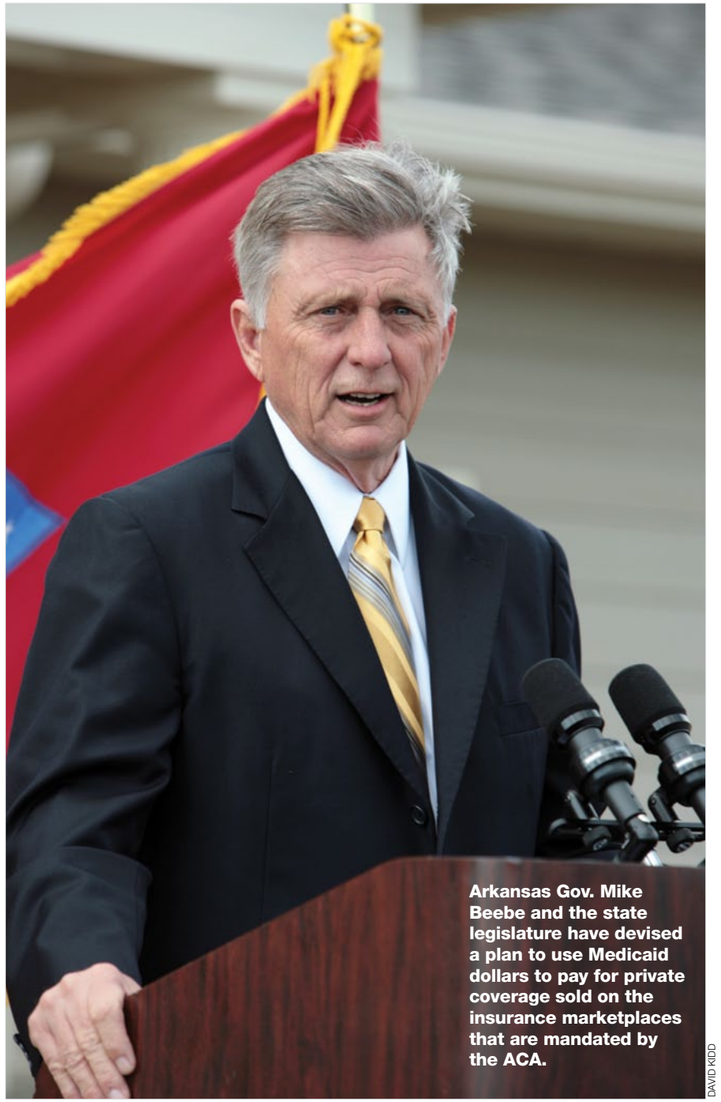
Protesters and supporters react to the Supreme Court's decision to uphold the Patient Protection and Affordable Care Act.

Forward, Together: Collaboration for Health Care Solutions

Our health care challenges are the same. It's time we came together for solutions.



Arkansas Gov. Mike Beebe and the state legislature have devised a plan to use Medicaid dollars to pay for private coverage sold on the insurance marketplaces that are mandated by the ACA.

DAVID KIDD

Politics, the old saw goes, makes strange bedfellows. So does governance — especially now. Institutional silos are slowly but surely opening up, and leaders are reaching out and collaborating with one another to leverage resources — financial, technological, workforce and, perhaps most important, mind power — to address many of the biggest challenges in the HHS space.

Medicaid Reform

Medicaid spending accounted for an estimated 24 percent of state spending in fiscal year 2011, and increased by 20 percent in fiscal year 2012 (following a 23 percent increase in fiscal year 2011), according to the National Governors Association and the National Association of State Budget Officers.[1] That number will only continue to rise with Medicaid expansion, which makes reforming Medicaid arguably the most pressing issue that every state now faces.

The most innovative and daring approach to this challenge is seen in Arkansas. Gov. Mike Beebe and the state legislature devised a plan to use Medicaid dollars to pay for private coverage sold on the insurance marketplaces that are mandated by the ACA. This public-private partnership is being watched and copied in various forms, especially in Republican-led states that rejected expansion politically but see the value in it fiscally.

This idea was surprising even to the state's own Medicaid director, Andrew Allison. "I did not see this solution coming," he admits. "It was a pretty quick marriage between previously independent worlds: private insurance and Medicaid. This option brings those two together. We have long worked side by side, but now we are working together on a daily if not hourly basis to flush out the details. All of us here in Arkansas are walking through the process of discovery together, like a scientist discovering a new element or compound."[2]

Among the novel approaches his state is taking is an initiative in which providers monitor "episodes of care"[3] for common and chronic conditions, including upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF) and attention deficit/hyperactivity disorder (ADHD). Providers share in the savings or excess costs of an episode depending on their performance for each episode. For each episode, all treating providers will continue to file claims as they have previously and will be reimbursed according to each payer's established fee schedule.

"I am incredibly excited about our innovation," Allison says, "and the profound impact it will have on the marketplace."

Integrating Eligibility

The State Innovation Models Initiative, under the aegis of the Centers for Medicare and Medicaid Services (CMS), funded a $300 million war chest to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation.[4] CMS is serious about transforming and improving health system performance. So are many states.

Louisiana, for example, was an early adopter of express lane eligibility (ELE). Created by the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, ELE allows Louisiana Medicaid staff to collaborate with the Department of Children and Family Services to automatically enroll children who are eligible for one program, like the Supplemental Nutrition Assistance Program (SNAP), into another program like Medicaid or CHIP. This reduces the need for applicants to submit enrollment paperwork twice for each program.

COLLABORATION, NEW ENGLAND STYLE

THE NEW ENGLAND STATES CONSORTIUM SYSTEMS ORGANIZATION (NESCSO)[5] is a nonprofit corporation organized by the six New England Health and Human services agencies and the University of Massachusetts Medical School. Its mission is to foster communication and collaboration among members by providing a framework for knowledge exchange in order to maximize policy, program and cost effectiveness.

The consortium began 12 years ago, says Executive Director Brenda Harvey, to address two goals: data sharing and multistate purchasing, mostly in Medicaid but with hopes of addressing other social services like SNAP and the Women, Infants and Children (WIC) program. Its greatest success so far, she says, is in allowing state commissioners "to get to know each other in an informal way. It is pretty overwhelming work, and to be able to sit around a table and pick the brains of colleagues and follow up with a phone call is helpful."

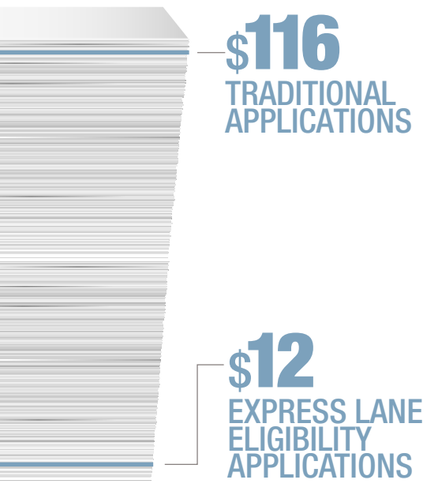
Brenda Harvey, Executive Director, NESCSO

But Harvey hopes that, as ACA implementation requirements abate and "it's not always the crisis of the day, maybe we can take a breath and take a better look at collaboration."

Multistate purchasing is high on her agenda. "There is nothing in the law that says we can't do it," she says. "But to get past that we need the purchasers to come to the table with an HHS cabinet member and sell the idea that a little flexibility is good and this is how we can be creative. If we can make them champions of this — I would like to see that as a reality in the next year or two — I think that is a model for the rest of the country."[6]

As the first state to adopt ELE, Louisiana enrolled more than 10,000 children into Medicaid in February 2010 based on SNAP data matches, an Urban Institute report reveals.[7] And when that first group of ELE children came up for renewal, 92 percent of those who had used their cards retained Medicaid based on their continuing receipt of SNAP, the report says.

ELE not only saves clients headaches, it also saves the government time and money. ELE-processed applications cost just $12 to $16, compared to $116 for traditional applications, the state says.[8] While the program had a $600,000 price tage, it cost the state nothing as it was established with a grant from the Robert Wood Johnson Foundation's MaxEnroll project. That investment cut costs by an estimated $8 million to $12 million the very first year, the Urban Institute report states, a return on investment of between 15 and 22 to 1.



A 2012 survey for the state's Department of Health and Hospitals conducted by LSU's Public Policy Research Laboratory found that the rate of uninsured children dropped from 5 percent to 3.5 percent during the past two years, a record low in the state and a big drop from the 11.1 percent rate just eight years earlier.

"It pretty much runs itself," Penny Chapman, Louisiana Medicaid program supervisor, says of the ELE program.[9]

Sharing Data

Sharing data across state departments has long been a goal of HHS agencies, but one of the unintended consequences of the ACA has been the fostering of numerous, extensive state-federal data-sharing partnerships.

With just 16 states and the District of Columbia running their own health insurance exchanges, fully two-thirds of the country is either partnering with the federal exchange (7 states) or relying on it entirely (27 states).[10]

Fed-state data sharing is also coming into play in an effort to get control over those individuals who are eligible for both Medicare and Medicaid and are the highest-need, highest-cost patients in the health care system. Under CMS's *State Demonstrations to Integrate Care for Dual Eligible Individuals*, 15 states have been awarded up to $1 million each to design new approaches to better coordinate care for these patients.[11]

"We spend about $350 billion on the 10 million people who are eligible for both programs," says Tim Engelhardt, director of the Demonstration Models and Analytics Group at CMS. He says these demos are working to overcome "barriers in the health care world," among them poor physician communication and collaboration, limited access to services and what he calls "financing misalignment."

"Medicaid takes on care coordination and management and tries to keep people out of the hospital and emergency room, but the benefits of those efforts often accrue to the Medicare program and the feds, not the states," Engelhardt says.

The first demonstration project to go live was in Washington state in July. CMS is providing Medicare data to use in a state-developed predictive modeling system to help identify the patients at highest risk for adverse outcomes and target "high-touch, high-intensity" interventions to prevent more costly hospitalizations. "This is one of our poster children for intelligent, innovative use of data [sharing]," he says.

Massachusetts, the first state to execute a demo agreement with CMS, has created a capitated, managed care model for dual-eligible individuals. This program, to roll out in October, "is a great test case," Engelhardt says.

These and other demos will be closely watched, of course. "Over time, we will build metrics and evidence of their effectiveness," Engelhardt says. "If they are, we'll keep them; if not, we'll stop them. A year from now, my biggest hope is that we have started to make changes on the ground in the way the providers work with Medicare-Medicaid enrollees, and with good outcomes to follow."[12]

> "It's complicated. We need intensive collaboration between the state and federal government. We have 50 states with totally different orientations in this world. Blending Medicare, which is standard and consistent across the country, with the different states is inherently complex. We've known this since 1965, and it hasn't been solved since then."
>
> – **Tim Engelhardt**, Director, Demonstration Models and Analytics Group at CMS

Patient-First Collaboration

South Carolina has also implemented policies that reflect and foster an integrated philosophy of technology and goal-oriented delivery among agencies and stakeholders.

The state has used the ELE program to streamline and simplify Medicaid renewals and applications for children.[13] Prior to 2011, the state saw 140,000 children "churn out" of Medicaid and CHIP on average annually, and 90,000 were re-enrolled within the next year. Using ELE, South Carolina utilized data from SNAP and Temporary Assistance for Needy Families (TANF) to determine eligibility for children. Further efforts to reduce the amount of paperwork for renewal and increased online access have been undertaken, and the state approved 65,000 children for coverage within the first eight months. Over half of those children have received services or are enrolled in a managed care plan. For its efforts, South Carolina was one of seven new states to earn a performance bonus from CMS, which rewards states for successfully enrolling eligible children in Medicaid.

South Carolina is also a demonstration state for dual-eligible (Medicaid and Medicare) coordination. "We're about a year away from launching our duals program," says John Supra, CIO and deputy director for eligibility and beneficiary services at the South Carolina Department of Health and Human Services.

Both initiatives reflect the idea of integrated delivery of services. "We need to think about what is the right set of care for people in these circumstances," he says. "We need to shift away from funding-stream-driven thinking toward holistic, citizen-driven thinking. It is a better investment, and makes more sense for the citizens we serve."

Like others in HHS, he is at times confused, confounded and overwhelmed by the ACA. "In the near term, I see a lot of uncertainty with ACA," he says. "It is difficult to predict exactly what is going to happen and how it will impact us and our citizens." But he also sees beyond the short-term deadlines. "Our team is so focused on Oct. 1 and Jan. 1," he says. "I try to get them to think about our efforts as laying the groundwork for delivering services better in the future."[14]

Fraud, Waste and Abuse

In February 2013, Dr. Naveed Ahmad of New York City was charged with billing Medicaid for more than $455,000 in unnecessary procedures and prescriptions and Medicare more than $10,000 in unnecessary procedures and prescriptions. Dr. Ahmad, who may also have fraudulently billed Medicare for an additional $2 million and Medicaid an additional $716,000 for procedures and $7 million for prescriptions, was caught by a collaborative team of local prosecutors, New York City agencies, the federal Health and Human Services Office of the Inspector General and the United States Attorney's Office.[15]

This state-federal collaboration, the first of its kind according to the Kings County District Attorney's office in Brooklyn, combined that office with Loretta E. Lynch, U.S. Attorney for the Eastern District of New York; Kathleen Sebelius, U.S. secretary for Health and Human Services; Daniel Levinson, inspector general for HHS; Robert Doar, commissioner of the New York City Human Resources Administration; and James Sheehan, HRA's chief integrity officer. Kings County District Attorney Charles J. Hynes also announced the creation of a new Healthcare Fraud Division within his office to handle the cases generated by the collaboration.

Health care fraud costs the government an estimated $80 billion

KATHERINE HERNDON, TBB-SC

> "We need to shift away from funding-stream-driven thinking toward holistic, citizen-driven thinking. It is a better investment, and makes more sense for the citizens we serve."
>
> – **John Supra**, CIO and Deputy Director, Eligibility and Beneficiary Services, South Carolina Department of Health and Human Services

a year.[16] With Medicaid expansion, that number has the potential to expand along with it. That makes fraud, waste and abuse prevention a critical component of HHS work. Collaboration on the back end is one solution. "Teaming up federal and local law enforcement agencies amplifies our impact in the fight against Medicare and Medicaid fraud," says Levinson.[17]

Collaboration on the front end — preventing fraud before it happens, rather than the traditional pay-and-chase model of fraud recovery — is also important, and Florida, the state with the highest per capita identity theft complaints, is experimenting with a new way to weed out potential fraudsters in its public assistance programs.[18] Florida is working with a private vendor to pilot an automatic online identity authentication system for three types of public assistance: Medicaid, TANF and SNAP.

The Florida Department of Children and Families (DCF) currently receives 90 percent of public assistance applications online, which entails a manual review of applicants' self-reported information across multiple databases and a follow-up phone call. This analytics model functions more like online financial services in the private sector, where software verifies a person's identity based on a few items of personal information.

Last year, Florida recorded nearly 70,000 identity theft complaints, equal to 361.3 complaints per 100,000 state residents, according to a February report from the Federal Trade Commission.[19] About 1.6 percent of nationwide identity theft complaints, the report said, involved government benefits applications. So far, the Florida pilot program is on pace to save the state close to $80 million, which is $50 million more than originally projected.

"What we're trying to determine is that the person does exist, that it's not a made-up identity and that they are who they say they are," says Susan Vitale, deputy secretary for DCF. Rather than recouping money from someone already exploiting the system, this would stop it "upfront, at the door and not [let] them in," Vitale says. "That is a very big paradigm shift." +

FIGHTING FRAUD WITH ELIGIBILITY VERIFICATION

ACCORDING TO A GOVERNING INSTITUTE SURVEY which queried nearly 130 state and local government leaders:

80% of respondents indicated that eligibility verification is either very important or one of the most important initiatives to **achieve their overall agency mission.**

said that once a recipient is in the program, they re-verify their data to make sure it meets eligibility requirements once every six months. Thirty-three percent of respondents do this once a year.

37% said it was not possible for a beneficiary to establish an **identity in multiple jurisdictions.**

53% said that the issue of **eligibility fraud will increase in importance** over the next two years.

62% said that insufficient resources **(budget** and/or **personnel)** is one of their organization's biggest challenges to eligibility fraud prevention.

69% said **accuracy of determinations** was the most important area of the eligibility determination process that needs improvement.

Source: GOVERNING Institute Eligibility Verification survey, 2012. Underwritten by Experian.

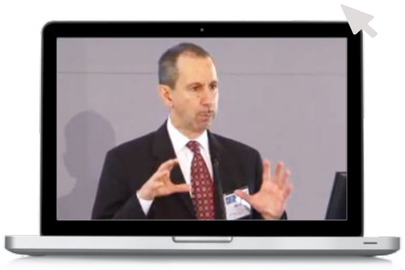
ACA: From the Wild Card to the Trump Card

Inversion and the changing role of the states and localities

The Affordable Care Act is, at the most basic, boots-on-the-ground level, an enormous burden for state and local HHS employees already collapsing under the weight of increasing service demands, shrinking budgets and disappearing staff. It has required nearly every minute of time and energy that these staffers have expended over the past 12 months. The moment President Obama was re-elected and the act was finally recognized as permanent, the ACA went from political wild card to policy trump card. "We spend all day, every day, preparing for the ACA," says Edward Fowler, Medicaid program manager of the Louisiana Department of Health and Hospitals. "I can't imagine how anyone does anything else."[20]

View the video on "Leveraging Health Care Reform and Other Federal Efforts to Build and Sustain Interoperability within Human Services" with David Hansell.

www.youtube.com/watch?v=KWWKEAz6gxw



But look deeper and you'll see something much greater than long workdays and frustrating red tape. In a 2011 panel discussion called "Leveraging Health Care Reform and Other Federal Efforts to Build and Sustain Interoperability within Human Services," David Hansell, acting assistant secretary with the Administration for Children and Families at HHS, said that the ACA has presented states with an opportunity for "a peaceful revolution in the way we think and do business in health and human services." He continued: "The conditions are uniquely right for states and the federal government to band together and storm the barricades of old-think." Of the ACA, he said, "If ever there were an action-forcing event, this is it."[21]

It certainly has forced action. And then, it forced reaction, as subsequent phases of ACA implementation brought with them new mandates and rules. For one, HHS has said that states can move from using the federal health insurance exchange to a partnership or state-run exchange in 2015 and beyond. Because the states, which regulate their own insurance industries, are better positioned to oversee the marketplaces, many expect them to do so.[22]

Those that already have their exchange running will be able to add other HHS programs into the architecture, moving toward a more seamless integrated eligibility platform and ever closer to realizing the dream of "no wrong door" to enter social services. (Indeed, some states are already there.)

> The most profound policy implication will be ACA's test of how much diversity the country can tolerate and how much uniformity it will demand.

Delaying the employer mandate until 2015 also changed the rules mid game. This has implications both in the private sector and within state and local governments themselves, which also have to comply with the law.

These and other changes imply that today, the ACA is version 1.0, with 2.0, 3.0 and beyond promising improvements both predicted and unforeseen. The ACA's broader, longer-term impacts will be seen in levels of access and enforcement across the 50 states, shifting cost burdens and control, which bring with them both budget and operational changes — many of them quite positive.

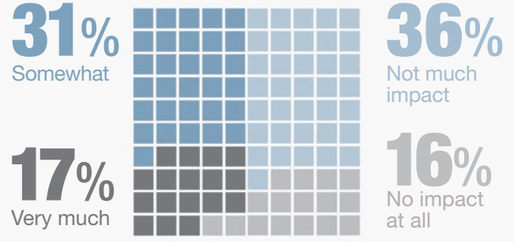
For instance, some state and local entities have discovered that the ACA offers a possible solution to the growing burden of retiree health benefits. The exchanges could give state and local retirees an alternative way of receiving health coverage until they qualify for Medicare, relieving their former employers of the need to provide post-employment benefits. The online marketplaces would allow retirees — many of whom would likely be eligible — to shop for affordable plans and access federal tax subsidies to pay for them. The city of Chicago is doing it now, and Detroit is looking at it closely.[23]

Indeed, studies are revealing that, across HHS departments as a whole, the ACA will end up saving states more money than it will cost, writes Carolyn Bordeaux, associate director for research at the Georgia State Fiscal Research Center.[24] "While it is wise to be cautious about such claims, when assessing the impact of health care reform, state and local governments should look beyond the health care sector. The possibility that health care reform will transform services across state budgets is quite real," she says.

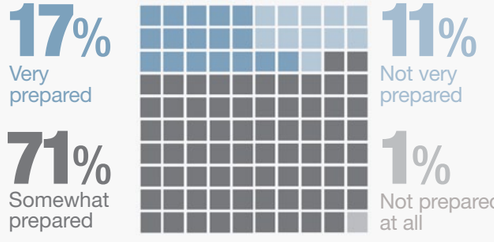
Taking this long view, then, reveals that the ACA trump card is truly "a valuable resource that may be used, especially as a surprise, in order to gain an advantage."[25] It's a card that state and local governments would be wise to play. "We have a front seat at the revolution," Hansell concluded in 2011. "Let's not waste our moment."[26]

The GOVERNING Institute surveyed 150 state and local government leaders regarding the ACA:

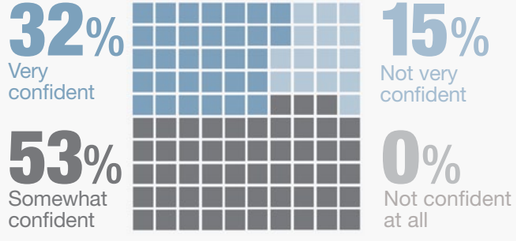
The election results' impact on organization's health care benefit decisions:



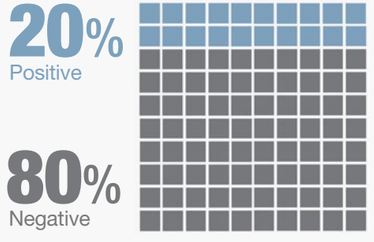
Level of organization's preparedness in preparing for future ACA provisions:



Organization's confidence in moving beyond a "wait and see" approach with the ACA:



ACA provisions' effect on organization's business practices:



Source: GOVERNING Institute Survey, 2013, underwritten by Kronos.

Outpacing, Outsmarting, Outmaneuvering

So you have a looming health care crisis on your hands. Get ahead of it.

The numbers don't lie. Americans, especially those who tend to be enrolled in social services programs, are more overweight or obese than ever. They have more chronic health conditions, such as diabetes, asthma and heart disease. With the expansion of Medicaid, millions of these people will suddenly be able to access health care for which they previously weren't eligible.

At the same time, America is aging. The nation's fastest growing population is age 85 and over, and this population, currently numbering about 4 million people, could top 19 million by 2050.[27] They will need more health care too.

But there are not enough primary care doctors and nurses to treat all of these people. By some estimates, the United States will require nearly 52,000 additional primary care physicians[28] and 260,000 nurses[29] by 2025.

Simple economics teaches us that when demand rises, supply should increase to meet it. However, our health care system never studied Economics 101, so government needs to step in. And throughout the country, it is doing just that. On the federal, state and local levels, public and private sector agencies are creating exciting, innovative and sometimes radical solutions to address both supply-side shortages and demand-side expectations. In the process, they are transforming how Americans deliver and receive health care.

A doctor consults with a patient who is more than 400 miles away using telehealth technology.

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Supply Side: Governments Help Meet Demands

"We are very concerned that we're going to hand insurance cards to 30 million people and we won't have the doctors to treat them," Dr. Atul Grover, the chief public policy officer at the Association of American Medical Colleges (AAMC), told NBC News in May. His group estimates even higher doctor shortages, expecting the deficit to grow to 100,000 physicians in the next decade.[30]

Getting more doctors through medical school and into underserved areas is the long-term goal of the AAMC and other medical organizations, but in the interim, other initiatives are underway to help today's physicians meet the needs of their growing patient base.

Telehealth initiatives

One-on-one Web-based video chats and other electronic consultations between doctors and patients have been in use throughout the U.S. for several years now, but with the supply of doctors low, telehealth is poised to become a more common and widespread practice.

Improved fiber-optic lines and faster broadband connectivity now allow doctors to practice online before and after normal working hours, ultimately serving more people. The California Telehealth Network, for example, is providing service in California, particularly in underserved rural and urban areas. The network works with stakeholders to establish broadband connectivity for communities and has already helped establish more than 350 telehealth sites in the state.[31]

Colorado, for another example, has taken telehealth into the prison population.[32] The Colorado Department of Corrections and Denver Health Medical Center launched a pilot program in June 2013 for incarcerated patients that need consultations in the areas of rheumatology, infectious disease, orthopedics and general surgery. Instead of office visits, inmates and doctors meet using high-definition video conferencing. The state hopes the program will reduce the risk of prisoner escape and save money by avoiding costly offsite trips to the medical center. Nineteen corrections facilities in Colorado will take part in the telemedicine effort.

If it proves successful, this program may expand to include other specialties and hospitals in the future. It may also be updated from simple video conferencing between the inmate and doctor to the transmission of images and other medical data as appropriate. "I want to be able to show that the technology these days is not the issue," Chris Wells, director of healthcare information technology architecture in the Colorado Governor's Office of Information Technology, told *Government Technology* magazine. "You can do this over the Internet. E-commerce, online retailers [and others] have been able to transmit sensitive data for years. So expanding this out to health care is the next level."[33]

Other states are also embracing telehealth. In July, Missouri became the 19th state to enact a statewide parity law for private insurance coverage of telehealth.[34] The law requires private insurers to reimburse health care providers for telehealth-provided services on the same basis as they would for in-person services and prohibits private insurers from denying coverage of telehealth-provided services. There are no restrictions on the type of technology that can be used, and the law uses a very broad definition for telehealth: the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient. The law goes into effect Jan. 1, 2014.

The New Mexico Medical Board will issue a telemedicine license to any health care provider outside the state who is licensed in any other state or territory in the United States.[35] About a dozen other state boards have modified their licensing requirements to allow some kind of telehealth practices across state lines as well.

But for telehealth to really take off, the remaining state governments need to update their rules and regulations for 21st-century medicine. Along with cross-state practice licenses, another hurdle is the requirement that doctors establish a physician-patient relationship in order to prescribe medications. Only 12 states allow an electronic examination to meet the requirements of a face-to-face examination.

Payment for telehealth services is yet another roadblock to telehealth expansion. Only 15 states, including Michigan, Maryland and California, have legislation requiring health insurance providers to

IN FEBRUARY 2013, Sens. John Thune (left) (R-S.D.) and Tom Udall (D-N.M.) introduced legislation to improve access to emergency services in rural and medically underserved areas through telehealth technology. The Strengthening Rural Access to Emergency Services Act would amend the Emergency Medical Treatment and Labor Act (EMTALA) to allow eligible hospitals in rural and medically underserved areas to use interactive telehealth programs to satisfy the federal emergency room staffing requirement for an "on call" physician when an associate provider is already on site at the rural emergency room.[36] GovTrack gives it a zero percent chance of passing out of committee, however.[37]

New Mexico Gov. Susana Martinez signed a bill that allows certified midwives and nurse practitioners to perform certain ultrasound procedures.

FLICKR/SUSANA MARTINEZ

recognize claims for services rendered through telehealth. In those 15 states, if an insurance policy covers an in-person medical visit and the physician feels they can treat the policyholder using telehealth, then an insurance company can't deny payment of that electronic visit.

Scope of practice laws

States can't just mint new M.D. degrees, but they can address the shortage of doctors and nurses with "scope-of-practice" legislation, which sets standards for what medical services health care professionals can perform. As of April 1, 2013, there were 178 scope-of-practice-related bills proposed in 38 states and Washington, D.C., according to the National Conference of State Legislatures (NCSL).[38]

A common strategy among the states is to allow nurse practitioners to perform more basic primary care and even open their own clinics. At least 50 bills related to nurse practices have been introduced in 22 states. According to the NCSL database of scope-of-practice legislation, states are trying several other unique ideas as well. Among them:

NEW YORK has introduced a bill that would allow doctors with out-of-state licenses to practice within its borders. The bill would require these doctors to be sponsored by an in-state organization and to work voluntarily.

MAINE enacted legislation that allows pharmacists, who can now give shots to adults, to also be able to vaccinate children ages 9 and older with a doctor's prescription.

NEW MEXICO Gov. Susana Martinez signed a bill that revised the state code to allow certified midwives and nurse practitioners to perform certain ultrasound procedures.

INDIANA legislation created a state midwifery board to set qualifications for certified midwives, develop standards for education and training, and establish penalties for practicing without a license.

NEW JERSEY is considering letting nurse practitioners determine the cause of death and sign a death certificate if a doctor isn't available. New York has proposed allowing physician assistants, under the supervision of a doctor, to issue a death certificate.

Demand Side: Governments Encourage Healthy Behaviors

Given: An ounce of prevention is worth a pound of cure. Therefore, it follows that to reduce demand on services (the cure), it pays to help people stay healthy (prevention).

Western medicine has been slow to embrace this concept, but as costs for care continue to skyrocket, prevention becomes more critical. Exhibit A: The nonprofit organization Trust for America's Health (TFAH) produced a report called "F as in Fat: How Obesity Threatens America's Future 2012,"[39] which projected that by 2030, every state could have an obesity rate above 44 percent and the country as a whole would be spending an additional $48 billion every year on related diseases. That same report also estimated that a 5 percent drop in Americans' average body mass index would save tens of billions of dollars.

A national prevention strategy to provide incentives for healthy behavior among Medicaid recipients has been a non-starter to date,[40] but many states and localities are finding ways to encourage good health and improve both waistlines and bottom lines. Common solutions include construction of multi-generational playgrounds, creation of "fitness zones," giving tax breaks to grocery stores to move into so-called "food deserts" and similar healthful initiatives. Some communities are going even further.

Creating communities that promote healthy choices and healthy living

Maryland: Health Enterprise Zones

The Maryland state legislature has allocated $16 million for a four-year pilot program that aims to reduce health disparities among racial and ethnic minority populations and among geographic areas; improve health care access and health outcomes in underserved communities; and reduce health care costs and hospital admissions and re-admissions.[41]

In January 2013, the first five Health Enterprise Zones (HEZ) were chosen.[42] Community coalitions in each area will receive a range of incentives, benefits and grant funding to address unacceptable and persistent health disparities. The proposals include:

- Building a new community health care center and hiring five new primary care practitioners, one psychiatrist and two licensed social workers; and developing a "health care transportation route" to address barriers to accessing health care in an HEZ in a rural area of the state.
- Adding 18 new providers and creating a new mobile mental health crisis team to target individuals who visit hospital emergency departments for behavioral health conditions.
- Creating five new patient-centered medical homes and adding 25 new providers to serve a minimum of 10,000 residents in a neighborhood that leads Prince George's County in poor health outcomes, including low birth weight, late/no prenatal care and teen births, and whose population is 95 percent racial/ethnic minorities.
- Establishing a new patient-centered medical home inside of a senior housing complex by adding one full-time physician, two full-time medical assistants and one full-time case manager in an area with high rates of emergency room utilization, hospital admissions and re-admissions and a large volume of medical 911 calls.
- Recruiting 18 new primary care professionals, deploying 11 community health workers and improving access to community health resources such as healthy food retailers and exercise facilities in a community with some of the highest disease burden rates and worst social determinants of health care in the state.

In January 2013, Maryland chose its first five Health Enterprise Zones.

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Fresh produce from the New Light Missionary Baptist Church vegetable garden, located north of Baton Rouge.

FACEBOOK/ SOUTHERN UNIVERSITY AGRICULTURAL RESEARCH AND EXTENSION CENTER

Baton Rouge: The Mayor's Healthy City Initiative

In 2010, the National League of Cities (NLC) created the Healthy Southern Cities Grant to advance local efforts to combat childhood obesity. The grant funded community wellness plans to expand access to fresh, healthy foods and opportunities for recreation. The NLC's Institute for Youth, Education, and Families (YEF Institute) selected three cities to participate in the first phase of its Municipal Leadership for Healthy Southern Cities technical assistance project: Little Rock, Ark., Baton Rouge, La., and Tupelo, Miss. Each city received customized technical assistance from the YEF Institute and other national experts.

Baton Rouge created the Mayor's Healthy City Initiative (MHCI)[43] "to identify and coordinate efforts aimed at healthy eating and an active lifestyle into a unifying community commitment to better health." A collaboration of government, private sector and nonprofit organizations, the MHCI is subdivided into three parts.

1. "Healthy BR" focuses on preventing negative health outcomes by encouraging healthier eating and more active lifestyles.
2. "Med BR" addresses access to care and health outcomes.
3. The "Innovation Center" conducts research and data analysis to help understand current levels of community health and set goals for the future.

The mayor's initiative exists to:

- Raise awareness within the community of the problem and the services available.
- Motivate community members to make healthy choices and to join the movement to make Baton Rouge a healthier community.
- Increase the number of visitors to health-related resources on any city website.
- Increase media outreach through community events and the website Healthybr.com.
- Increase awareness of HealthyBR.com and the partnering organizations.
- Increase utilization of available resources to promote healthy eating and active living in Baton Rouge.

Promoting health by discouraging unhealthy food choices

Studies show that low-income Americans — the population that receives food stamps through SNAP – are more likely to have a nutrition-poor diet[44] and therefore are at a bigger risk for obesity and its associated medical conditions. Wisconsin and South Carolina are hoping to limit what kinds of food people can purchase with food stamps to encourage beneficiaries to buy more nutritious groceries.

The U.S. Department of Agriculture (USDA), which jointly administers SNAP with the states, has to approve waivers to make changes to food stamp programs, and the USDA has so far denied every waiver that sought to do what these states are proposing.[45] Wisconsin hopes to gain approval by creating guidelines rather than by banning certain foods. South Carolina wants to start a pilot program using the state's approved food list for the WIC food assistance program, a state-federal venture that does place restrictions on what foods can and can't be purchased with taxpayer dollars. ✚

Health Impact Assessments:

Considering Health in all Policies

All policy is health policy. That axiom is supported by a growing number of public policy advocates, including the National Association of County and City Health Officials (NACCHO) and its "health in all policies" initiative.[46] It is common sense, applied. For instance, there is a positive correlation between reducing childhood obesity and how close kids live to a park.

The idea is to determine how decisions like building new roads, changing industry regulations or developing neighborhoods impact the health of the community's citizens. One approach that communities are using more commonly to do that is to conduct a health impact assessment (HIA). The Health Impact Project,[47] a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable Trusts, is a national initiative designed to promote the use of HIAs as a decision-making tool for policymakers.

HIAs use "a flexible, data-driven approach that identifies the health consequences of new policies and develops practical strategies to enhance their health benefits and minimize adverse effects." According to the organization,[48]

The Detroit Urban Resource Center has received a grant to study the effect of reduced population and revenue in Detroit.

DAVID KIDD

a health impact assessment does a number of important things:

- Looks at health from a broad perspective that considers social, economic and environmental influences.
- Brings community members, business interests and other stakeholders together, which can help build consensus.
- Acknowledges the trade-offs of choices under consideration and offers decision-makers comprehensive information and practical recommendations to maximize health gains and minimize adverse effects.
- Puts health concerns in the context of other important factors when making a decision.
- Considers whether certain impacts may affect vulnerable groups of people in different ways.

Although HIAs aren't yet a routine practice (only 4 of 36 federal, state, local and Indian Tribe jurisdictions surveyed by Health Impact Project require an HIA by law),[49] the use of HIAs nationwide "is definitely taking off," says Dr. Aaron Wernham, director of the Health Impact Project He says more than 275 HIAs have been completed or are being conducted currently for various state and local projects, up from just 27 through 2007 — a majority of which are conducted collaboratively, without any legal requirement.

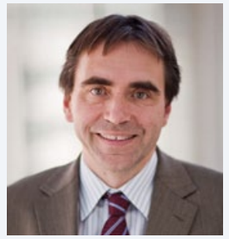
One state that has legally required HIAs is Massachusetts, which created the Healthy Transportation Compact[50] as part of its transportation reform legislation of 2009. The inter-agency initiative is "designed to facilitate transportation decisions that balance the needs of all transportation users, expand mobility, improve public health, support a cleaner environment and create stronger communities."

HIAs are also being used to:

- Explore the possibility of retrofitting or retiring the Shawnee coal plant in Paducah, Ky.
- Assess the health impacts on Native Americans if a new solar plant is built in the Mojave Desert.
- Analyze different proposals for overhauling the sanitation infrastructure in San Juan, Puerto Rico.
- Review impacts related to the proposed Wishbone Hill Mine in the Matanuska-Susitna valley near Sutton, Alaska.

A completed HIA contributed to the Oregon state legislature's decision in 2011 to pass a Farm to School pilot program, which encourages public schools to purchase their foods from local farms. A nonprofit, Upstream Public Health, completed an HIA before the bill was finalized, and lawmakers incorporated several of its recommendations into the final legislation. A pilot program was created that allowed schools to build gardens to add an educational component to the "farm-to-school" concept.

Detroit may be conducting one of the most ambitious HIAs ever. The Detroit Urban Resource Center has received a grant to study the effect of reduced population and revenue in Detroit, as local officials and a newly installed state emergency financial manager ponder how to encourage economic growth in their now-bankrupt city. The HIA will analyze new proposals from the public health perspective.



"We hope the HIA will prove to be a really useful lens (for Detroit), and it will help people think rationally and carefully about tradeoffs when you try to figure out how to help a community rebuild."

– **Dr. Aaron Wernham**, Director, Health Impact Project

"The city's been struggling for years with figuring out, 'How do you deal with a shrinking economy? How do you stock the police well enough? How do you keep schools open?'" Wernham says.[51] "They're in a very politically challenging environment. We hope the HIA will prove to be a really useful lens, and it will help people think rationally and carefully about tradeoffs when you try to figure out how to help a community rebuild."

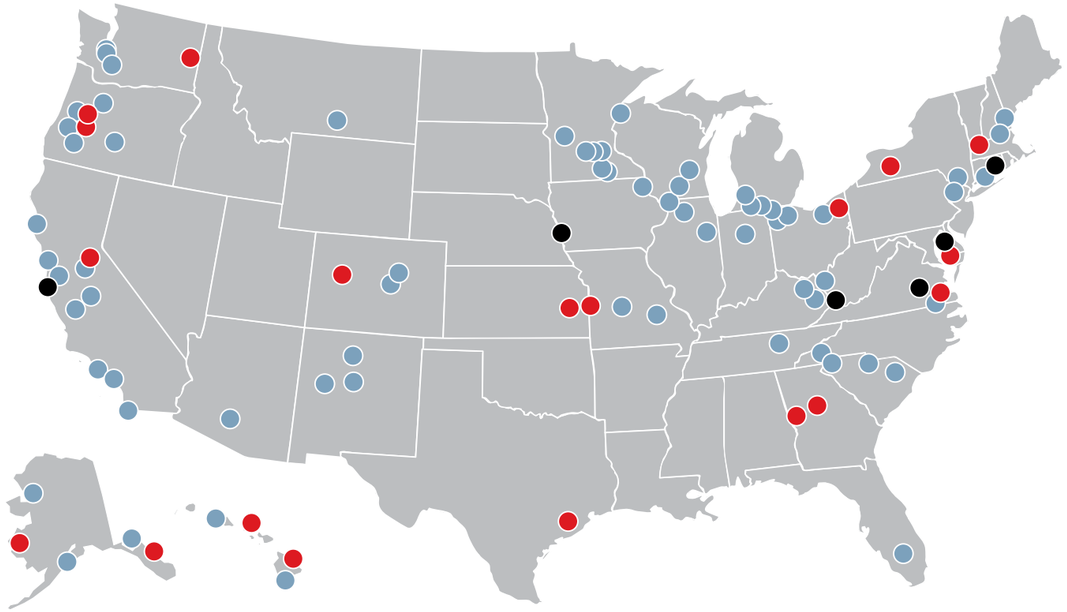
A former practicing physician, Dr. Wernham learned the power of environment on health when, as a resident, he had a 6-year-old asthma patient coming to the emergency room week after week, despite being highly medicated. "The mom said they lived in an old, rundown, moldy apartment," Dr. Wernham says. "I wondered if we could prescribe new housing." Today, HIAs are helping to, in essence, do just that. It takes interdepartmental collaboration, "agencies working together that normally haven't before," he says. And it is happening throughout the country. "It's one of most exciting things we have seen," he says. +

WHAT IS A HEALTH IMPACT ASSESSMENT?

According to the National Research Council of the National Academy of Science's 2011 report, "Improving Health in the United States: The Role of Health Impact Assessment": "HIA is a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects."[52]

HEALTH IMPACT ASSESSMENTS GAIN TRACTION NATION WIDE

THE HEALTH IMPACT PROJECT tracks HIAs across the United States. The map below indicates where HIAs have been implemented.



The Age of Intelligence

Never before have there been more powerful systems or more pervasive data to transform how health and human services operates.

DAVID KIDD

Look at the smartphone on your desk or in your pocket. Then consider this: It has more computer power than NASA had to land men on the moon in 1969.[53] Technology has transformed the world in nearly every way imaginable, including health care. If knowledge is power, technology is applied knowledge and actionable knowledge in the palm of your hand.

"The new ways we collect, store and analyze data are all critical for having the information we need to identify problems and create solutions," Farzad Mostashari, national coordinator for Health Information Technology at HHS, told the Robert Wood Johnson Foundation.[54] "Having data for decision-making, and the simple act of a clinician looking at data on their collective of patients, not just individuals, is the foundation of population health management. ... Our goal is not to have dead data that sits on shelves but to make it come alive by using it to improve the public's health."

That is also the goal of forward-thinking states and localities across a broad range of technological transformations.

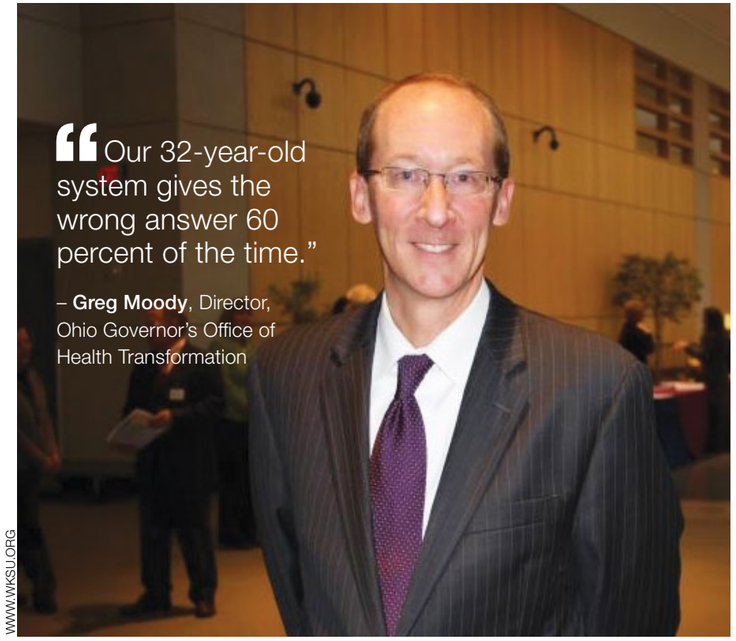
Legacy Modernization

The 90/10 federal funding match for eligibility systems has given states a once-in-a-lifetime opportunity to bring their legacy mainframes into the 21st century, and states like Virginia and Ohio have used that opportunity to integrate eligibility across many HHS departments.

> "In my first day on the job, I held a meeting and learned that our technology wasn't working for anybody. Our eligibility platform is 20 years old, and our error rate in Medicaid was 16 percent."
>
> – **Dr. William Hazel,** Secretary, Health and Human Resources, Virginia

"In my first day on the job, I held a meeting and learned that our technology wasn't working for anybody," says Dr. William Hazel, secretary of Health and Human Resources for the commonwealth of Virginia. "Our eligibility platform is 20 years old, and our error rate in Medicaid was 16 percent. Each agency had its own CIO, so we brought these CIOs together and learned there was almost no strategic planning and looking ahead. It became abundantly clear that we are not serving citizens optimally. Then along comes the ACA."

His department partnered with the state's Department of Motor Vehicles — "They know 70 percent of Virginia citizens," he says — to



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identify and authenticate constituents to support a newly purchased data management system. “We also had inherited a child-care services project, and we saw it would fit into the system we were buying.”

While the back office still runs on the legacy platform, the new system supported a Web portal for Medicaid, SNAP, TANF and energy assistance programs. A foundation grant has funded a pilot program to pull data from 150 state sources to help coordinate child care.

Once the ACA deadlines pass, the agency will migrate functionality from the legacy system to the new infrastructure, “which will become the basis for all HHS services,” Hazel says. “At the end of the day we hope to have a common platform that other agencies that provide consumer-directed service can use.”[55]

In Ohio, “our 32-year-old system gives the wrong answer 60 percent of the time,” says Greg Moody, director of the Governor’s Office of Health Transformation.[56] “The county workforce has to override the system to get it to give the correct result. So it was an obvious priority to replace.”

They also looked to build an enterprise system, “not just a Medicaid eligibility system, but also food stamps, TANF and eventually the possibility to include all income-based programs on the platform,” says Portfolio Manager Rex Plouck. “We will create one person-centered, holistic view of these services.”

They too are rolling out functionality over time, projecting to be fully off the legacy system by July 2015. It will include mobile-ready applications. “That is a requirement,” Moody says. “We want these services to be available to Ohioans on their own terms, and for many that is a tablet or smartphone — their phone is their computer.”

Changing technology is one thing, but changing working habits is sometimes an even bigger challenge. So they came up with the novel idea to procure two separate vendors, one for the machinery, the other for “organizational change management.” “Money can become consumed by technology, and you end up automating the way you already do business,” Moody says. “What Rex did was split the two components, which was a real innovation to avoid this trap.”

In October they will begin another phase to include analytics, business intelligence and data warehousing capabilities into the platform. “That is a big, big component for long-term perspective to help us make better decisions,” Plouck says.

“We are not breaking new ground here,” Moody says. “What is original is tackling multiple reforms simultaneously to get a critical mass of reforms that reinforce each other. You don’t have to build a whole new bureaucracy to innovate. You just have to convene the talent and let them know you value their creative solutions.”

Electronic Health Records

In 2000, the Institute of Medicine called for the use of technology, such as using electronic health records (EHRs) to prescribe medications electronically, as a way to reduce preventable errors. Eight years later, that was still mostly a dream; as of 2008, only 7 percent of physicians e-prescribed using an EHR. Since then, though, the practice has blossomed, so that by June 2012, nearly half of all physicians (48 percent) were e-prescribing.[57]

HHS has embraced EHR adoption, and its Office of the National Coordinator for Health IT (ONC) recently released the Health IT Patient Safety Action and Surveillance Plan to increase the quantity and quality of data about health IT safety; target resources and corrective actions to improve safety; and promote a culture of health IT safety.[58]

Data Analytics

The consulting group McKinsey & Company calls big data, “The next frontier for innovation, competition and productivity.”[59] It goes on to say that if the health care industry could use big data “creatively and effectively to drive efficiency and quality, the sector could create more than $300 billion in value every year.”

The Healthy Communities Institute,[60] a Bay Area project, is one initiative attempting to harness big data to “help local public health departments, hospitals and community coalitions measure community health, share best practices, identify new funding sources and drive improved community health.”

Its technology takes publicly available data on communities and creates Web-based dashboards for care providers or health care organizations. These analytics provide performance measures linked to public health interventions around such things as infectious disease rates and chronic disease patterns.

HCI, composed of health care IT professionals, academicians and former government officials, started in 2002 with the Healthy Cities Movement and the University of California at Berkeley. The principals have expertise in informatics, public health, urban sustainability, community planning and high-volume Internet sites. They took on this challenge, they say on their website, because, “First, although a lot of data is collected and stored, people don’t always know where to find what they need. Second, if they find it, it’s not necessarily presented in understandable ways. Third, once they do understand the information they found, it is not always clear what to do about it or how to get involved.”

As Thomas Goetz, managing editor of *WIRED,* explained to the Robert Wood Johnson Foundation,[61] “This organization has really combined the basic goal of public health, which is to maximize the health of a population in the most efficient way. ... [A]ll sorts of different data are coming online, so you look at things like environmental data and exposure data that you are able to map. You think about disease clusters and other kinds of efforts at understanding how to do this work in a geographic framework, but it’s just really been hard to connect what seem like patterns with actual correlations, because the data is very wispy. In this new mode of constant measurement and of combining data sets with much more agility, you are able to get, with much more certitude, to exposures and disease rates in populations, and basically open a new lens onto the geographic component, which is a huge component of community health.”

Leveraging Big Data

Data is just numbers. What communities do with those numbers is what makes big data powerful. It allows you to see correlations hiding in plain sight.

Take, for example, the Louisville Asthma Data Innovation Project.[62] There, asthma patients are being tracked by GPS implanted into their inhalers. Every time the patient uses it, the manufacturer takes the data, removes personal information such as the patient’s name and vital statistics, and gives it to a commission of city officials and health care providers. This data, combined with other public information like air quality, pollutants, traffic patterns and school absences, will allow Louisville officials to make decisions about how to create a healthier living environment for its residents.

Collaboration is, once again, the key. The project is a public-private partnership between the city, the inhaler manufacturer and another private sector partner that is funding the initiative. Pharmacies and physicians are distributing the inhalers; doctors will guide care based on the data collected (if patients allow it); and health care providers are overseeing the project and deciding what to do with all the information.

In another example of how analytics might improve public health, researchers from the University of Michigan, MIT, Harvard Medical School and Brigham and Women’s Hospital in Boston used data mining and machine learning techniques to analyze electrocardiograms from 4,557 heart attack patients enrolled in a large clinical trial.[63]

The analytics revealed that the readings from many of the patients who later suffered cardiovascular death contained similar errant patterns that were thought to be just noise. These heretofore unseen markers of heart damage could help doctors identify those patients at high risk of cardiac death and start them on interventional treatment before a heart attack occurs.

"There's information buried in the noise, and it's almost invisible because of the sheer volume of the data. But by using sophisticated computational techniques, we can separate what is truly noise from what is actually abnormal behavior that tells us how unstable the heart is," says Zeeshan Syed, an assistant professor in the University of Michigan Department of Electrical Engineering and Computer Science and first author of the study.

In Wisconsin, data is transforming care through the Wisconsin Health Information Organization. The WHIO is a voluntary initiative supported by leaders from insurance companies, health care providers, major employers and public agencies. Its big data initiative is called the WHIO Health Analytics Exchange. With data from about 250 million insurance claims for care provided to 3.7 million Wisconsin residents, the WHIO's database holds a rolling 27 months of claims data and a total of 23.7 million episodes of care. (An episode of care is defined as all the treatments and follow-up treatment related to a single medical event, such as a broken leg or heart surgery, or the year-long care of a chronic disease such as diabetes.)

All this data, along with WHIO analytical tools, is available to member health care organizations. Members of the Exchange, which the WHIO calls "a data-driven marketplace," both supply information and receive reports that analyze health system and physician performance based on hundreds of analytic variables. "The Exchange can be used to identify gaps in care for treatment of chronic conditions, costs per episode of care, population health, preventable hospital readmissions and variations in generic prescribing," the WHIO says.

"To achieve real and meaningful changes in health care delivery that will produce higher quality and more affordable care, information must be turned into action," it concludes.

That's the goal of all big data enthusiasts. ✚

IMPROVING INTEROPERABILITY

"TOO MANY BARRIERS STAND IN THE WAY of clients getting the services they need," says the Administration for Children and Families (ACF). "'Interoperability' — a national effort of technological and programmatic coordination — is poised to eliminate many of those barriers. Today, the emergence of 'interoperable technology' offers an unprecedented opportunity to connect systems across traditional boundaries in exciting and rewarding ways."

The ACF's Interoperability Initiative is supporting a State Systems Interoperability and Integration (S212) Project. As of May 2013, seven grantees were halfway through the one-year grant award period. The planning grant, funded by the Office of Management and Budget (OMB) Partnership Fund for Program Integrity Innovation, is helping the following states with their efforts to improve interoperability and integration across health and human services information technology systems:

- **CALIFORNIA** is promoting understanding of interoperability statewide and is developing a governance model.
- **COLORADO** is building a Client Information Sharing System (CCISS) that will facilitate collaboration and data sharing across its Department of Human Services and six other domains.
- **ILLINOIS** is developing a sustainable governance model.
- **INDIANA** is automating and improving the state's vital events registry (IVER) information, collection and data sharing.
- **MARYLAND** is defining interoperability and its impact on client outcomes at the practice level through its "Life of the Case" Workflow Analysis Model, and Return on Investment Models and Calculator.
- **NEW YORK** is developing an online reporting portal called Children's Passport (CP) that will capture data from multiple sources but will only focus on the health data using this grant money.
- **OKLAHOMA** is building a roadmap that will help redesign the eligibility and enrollment system, and to integrate service-oriented architecture (SOA) and the Enterprise Service Bus (ESB).

Systemic Vital Signs and a Path to Recovery

The system is the patient, and exciting treatments are underway.

If 2013 will be remembered as a year of urgent response to Code Blue in health and human services, 2014 and beyond may be seen as the time HHS turned the corner, began a robust recovery and embraced an exciting future. With ACA implementation largely behind them, HHS employees will find themselves in a new world in which 21st-century technology has, at long last, armed them with the tools they need to do their jobs smarter, faster and more efficiently. And that will mean better care and service delivery for the constituents who rely on their programs.

Updated eligibility systems will provide open and easy access — no wrong door — for the growing number of Medicaid recipients who may also need other support services. Health-centered policies will lower demand long term, and in the near term, data analytics will help providers triage that demand to help focus care where it is needed most.

Coincidentally, big data will be employed to influence the behaviors of all involved — patients, providers, partnering organizations, and state and local government agencies. All of this data will give HHS thought leaders a way to drill down ever deeper into costs per unit of service, thus finding economic efficiencies not visible to the naked eye. Those efficiencies will help refine internal cost and delivery models to improve the health and extend the life of the system itself.

The work is far from done. Challenging roadblocks remain, budgets and staff levels aren't likely to increase anytime soon, and the ACA will continue to eat up time and money as its kinks are worked through. But those states and localities that have seized the opportunities afforded by the new health care law and its attending funding and intellectual opportunities are better positioned than ever to meet the challenges of human services delivery.

The late author Stephen Covey was often said to begin with the end in mind. Many states have. Namely, they have begun with a view of accomplishing their real mission: providing all citizens with the dignity of a decent life and the hope of a healthy tomorrow. ✚

Arkansas State Medicaid Director Andrew Allison is leading one of the most innovative approaches to Medicaid reform.

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> "All of us here in Arkansas are walking through the process of discovery together, like a scientist discovering a new element or compound. ... I am incredibly excited about our innovation."
>
> – **Andrew Allison**, Arkansas Medicaid Director

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PROVING PAY OR PLAY FOR THE ACA

Kronos helps state and local government achieve less costly and complex compliance

THE AFFORDABLE CARE ACT (ACA) is here to stay. And while it may have generated a significant amount of controversy, its complexity was never up for debate.

A key component affecting government leaders is the "Pay or Play" mandate, which requires employers with more than 50 full-time equivalent (FTE) employees to provide affordable health care coverage to employees who work more than 30 hours per week or 150 hours per month. Failure to "play" results in steep fines.

A recent GOVERNING Institute survey, underwritten by Kronos, queried 150 state and local leaders regarding their preparedness to comply with ACA employee benefits. Seventy-four percent of respondents noted they did plan to provide the coverage to their employees. However, this brings its own set of challenges — among them that the agency must prove to the federal government that they are, in fact, playing. For agencies that are struggling with reduced budgets and staff, the time and resources it takes to calculate which employees are full time in accordance with the ACA and prove compliance can be prohibitive — especially when many agencies are still relying on manual and paper-based workforce management processes.

According to the GOVERNING Institute survey, 50 percent of respondents either didn't have or didn't know if their current system or process allowed employees to enroll, opt out or waive ACA benefits. Additionally, 77 percent of respondents use or plan to use paper time cards or Excel spreadsheets to determine who is full time in accordance with the ACA.

Government agencies need integrated workforce management tools that provide complete automation and high-quality information for driving cost-effective labor decisions and minimizing ACA compliance risk. Kronos can help agencies:

→ LOOK BACK QUICKLY AND MOVE FORWARD

If an agency is using a paper-based process to track employee hours, determining if an employee meets full-time status might be a nightmare, requiring human resources personnel to manually examine many months of files and records. By tracking scheduled and actual hours worked for each employee within a specified timeframe, automated workforce systems can almost instantaneously provide agencies with accurate information.

→ PROACTIVELY MANAGE IN THE MOMENT

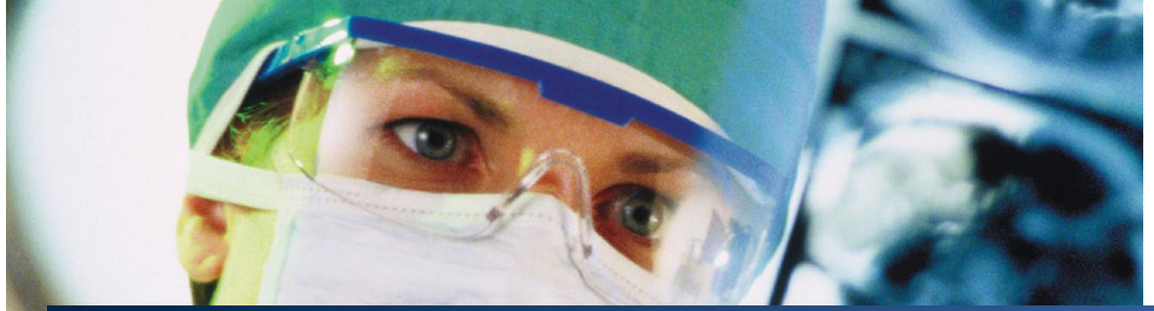
Automated systems provide dynamic visibility into employee hours worked. If an agency has determined that an employee is a part-time employee for ACA purposes, the automated workforce system can ensure that the employer becomes aware that the employee is approaching this threshold. This real-time reporting is impossible with paper time cards or Excel spreadsheets.

→ STREAMLINE ENROLLMENT WITH EMPLOYEE SELF-SERVICE

For FTEs who will be eligible for health care, an automated workforce management system can help streamline the enrollment process by enabling employee self-service into benefits programs.

KRONOS®

For more information, download the GOVERNING Institute's brief, "How Will the Affordable Care Act (ACA) Impact Your Government Agency?" underwritten by Kronos at www.governing.com/papers or visit **www.kronos.com/affordablecareact**.



SMARTER DATA, BETTER HUMAN SERVICES

ADVANCED ANALYTICS AND NEW DATA SOURCES ARE RESHAPING HEALTHCARE MANAGEMENT

Federal and state agencies that manage Medicare, Medicaid, and other human services programs face enormous pressure to serve more citizens with shrinking budgets—do more with less. The only way agencies can be successful is to get smarter about the people they serve and the healthcare these citizens consume.

One way CIOs are meeting this challenge is by integrating all health and human services data into a single, scalable data warehouse.

Unfortunately, most agencies have versions of data spread across multiple systems, which leads to excess hardware, inflated IT support costs, and wasted resources wrangling with data and tools instead of focusing on analysis. When analysts spend their energy doing analysis, the organization gets smarter and can do more.

A PHASED APPROACH

If the thought of integrating massive amounts of siloed data in a centralized data warehouse sounds overwhelming, it doesn't have to be. The best way to build a data warehouse is one data source at a time, much like agile software development. When the next subject area is folded in, the value of the whole increases exponentially.

To guide this effort, Teradata created a health and human services logical data model (LDM). It acts as a blueprint, describing and showing the relationship of all types of health and human services data in various systems to then populate the data warehouse with one subject area at a time.

DAVID WIGGIN

David Wiggin is the Program Director for Healthcare & Life Sciences at Teradata. He is also a faculty member with the International Institute for Analytics, Health Care Analytics Research Council, and a regular speaker at Duke University Health Sector events.

As analytics, data, and tools all grow and change over time, the Teradata platform scales easily and seamlessly to meet these new demands. In addition, centralizing data reduces the costs of hardware, tools and applications, encouraging a lean approach to software licenses.

GETTING VALUE FROM BIG DATA

A data warehouse is inherently designed to handle today's new kinds of multi-structured data (big data) and analytics. Instead of just analyzing transactions, big data analytics answers questions about interactions. These new data and new methods bring next generation capabilities to detecting fraud and abuse, performing audits and empowering citizen engagement with personalized, automated outreach. Enabling these analytics in a single unified architecture lowers risk and total cost of ownership.

At the end of the day, the combination of the integrated data warehouse, Teradata Aster big data analytics and Teradata Applications, creates unparalleled actionable analytic capabilities.

TERADATA.

View short video to see how the state of Michigan is improving services while saving millions.

Teradata.com/videos/michigan

WATCH VIDEO >

Streamlining the Eligibility Determination Process

Experian helps prevent fraud and theft, and improves benefits distribution to qualified applicants

The Problem with Preventing Fraud and Theft

Eligibility verification in the public sector carries with it an unfortunate challenge: It is becoming harder to identify and differentiate fraudsters from those who truly need public benefits.

Nearly 46 percent of state and local government leaders think fraud is a problem affecting every part of government. Qualifying criteria must be analyzed extensively to thwart fraud rings, syndicates and individuals with criminal intent who misappropriate public benefits. However, sifting through extra data is a time-consuming and expensive undertaking for agencies with budgetary and personnel shortfalls.

Faster, Better, Smarter Data

Experian Public Sector's Eligibility Assurance Framework℠ offers next-generation authentication, drawing from multiple layers of data that provide rich intelligence and enable better assessments. Experian's sophisticated tools mine and cross-reference data not typically included in other verification searches, providing:

- An integrated eligibility determination process for public service programs and benefits
- Income and asset estimation
- Continuous monitoring for eligibility
- Instant decision-making regarding applicants

Deep internal and external information and third-party data can help to swiftly target fraud, substantiate identity and confirm benefit entitlement. Individual profiles also can be monitored over time to prevent benefit overpayment should eligibility change.

If discrepancies are revealed, Experian's advanced data and analytics solution can determine recipients' capacity to repay and even help collect money owed. That's a significant advantage when you consider that outstanding government receivables currently run in the multi-billions.

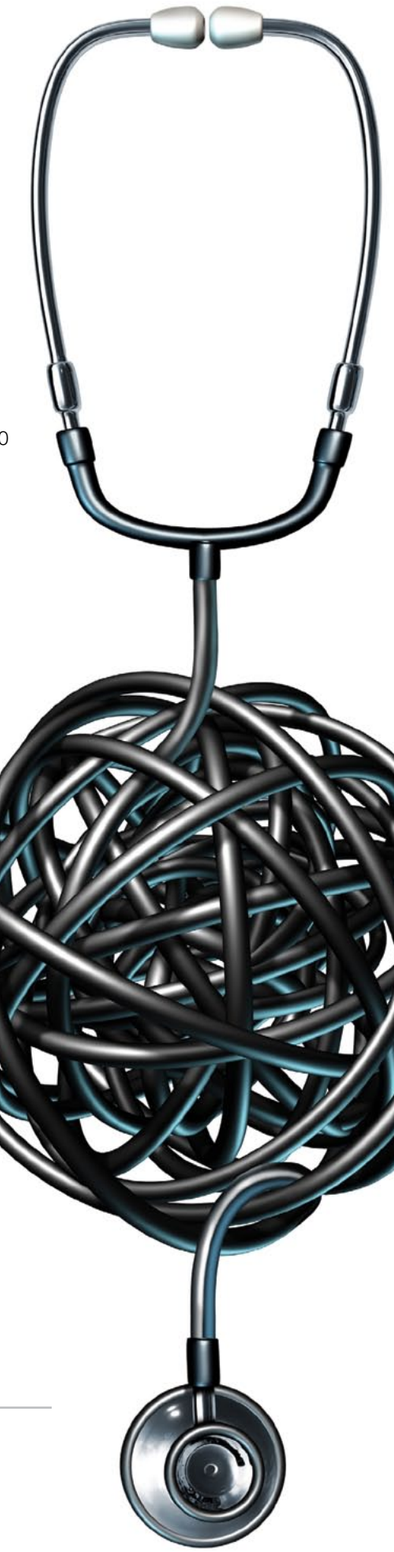
Experian's modular framework offers flexibility so agencies incorporate only pertinent information into their systems and interpret it meaningfully. This gives social service employees the power and effectiveness of real-time data that heightens decision making, prevents data loss and fraud, and improves benefits distribution to the constituents who need it most.

Experian℠ Public Sector

To learn more about Experian's Eligibility Assurance Framework, visit **www.experian.com/publicsector**

MANAGING THE CRUNCH:

Qmatic prepares HHS agencies for the rush of new caseloads with innovative customer flow solutions



UPCOMING REGULATIONS PROMISE TO USHER IN A NEW ERA FOR PUBLIC HEALTH IN 2014. In the process, caseloads are predicted to soar for public agencies that are tasked with serving millions of new beneficiaries but with limited resources. How will they manage the crunch?

Innovative customer flow management solutions can lighten the load. Qmatic, an industry-leading provider of this technology with over 30 years of experience and 55,000 installations worldwide, helps public service agencies better manage the customer journey. From automating the intake process, to scheduling appointments, to verifying arrivals — Qmatic enables agencies to improve productivity by up to 35 percent and shrink customer wait times by 30 percent.

Qmatic's advanced technology gives agencies the analytics and insight to improve an organization's efficiency and worker productivity. It can also help agencies improve customer service and reduce stress, for both clients and staff — resulting in a better customer experience.

Qmatic solutions include:

» **Caseload Management** — Manage caseload demand by assigning cases according to available resources and worker competence. Appointment scheduling can increase processing capacity up to 35 percent with same or fewer resources and balance client arrival by scheduling off-peak times. Load management is optimized, improving efficiency for both client and staff.

» **Lobby Management** — Clients check in for an appointment or service at self-serve kiosks. Informational and directional displays and monitors keep waiting clients informed and provide clear direction of where to go and when.

» **Mobile and Online** — Adds convenience and saves time by allowing clients to sign in prior to arrival via a computer or mobile phone. Improving the client experience reduces client and staff stress, and increases satisfaction levels.

» **Predictive Technology** — Critical analysis and reporting tools help management drive ongoing operational improvements while better supervising the day-to-day activities. The tools can track and analyze client traffic trends to predict future service, workstation and resource needs based on times, days and more.

» **Integration and the Cloud** — Qmatic systems can integrate with existing CRM programs or case management systems to enable analysis of transactions and performance, and maximize an agency's existing technology investments. The Qmatic application is also available via a cloud service.

Qmatic has a presence in 122 countries, with more than 55,000 installations worldwide. Their solutions help government health and human services agencies do more with same or fewer resources.

QMATIC
Valuing Time

To learn more, visit **qmatic.com/us**

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Get the Bigger Picture:

EMC Isilon NAS Scale-out Storage Solution

MEDICAL IMAGING has undergone a true renaissance in the last few years, with high-resolution digital and 3D technologies that are a boon to science but a challenge for those who must store such huge files. A single 60-second radiology scan can generate 10 terabytes of data — with health care demands predicted to spike exponentially over the next decade, the implications for storage are staggering.

The EMC Isilon Network Attached Storage (NAS) is ideal for high-volume, high-availability data environments where server sprawl is a concern. Offering advanced features and a wide range of connectivity options, the solution allows health care to keep patient video and still images well organized and easily accessible using image data consolidation.

Easy Use, Easy Access

Management and security features are included in a scalable, intelligent file system with a single point of management, giving users access to a plethora of tools and information without the hassle of a complex setup. This innovative architecture means that a single NAS cluster can be utilized for a variety of uses, such as radiology, cardiology, PACS, archives and more.

Under-provisioning or over-provisioning storage can waste space and efficiency and hurt your bottom line. With EMC Isilon, those worries are eliminated, thanks to the system's ability to scale on the fly to over 15 petabytes and adapt to quickly changing circumstances or emergencies with no complications and minimum downtime. Sensitive image data is protected and compliance guaranteed, with unique encryption capability and keys for separate users — a critical feature for Health Insurance Portability and Accountability Act (HIPAA) requirements.

EMC Isilon helps health care organizations reduce costs, improve operational efficiency and get the bigger picture — painlessly.

EMC ISILON

For more information, please visit
http://www.emc.com/industry/healthcare/scale-out-storage-healthcare.htm

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MorphoTrust Health Care Solutions:

Boosting program productivity while reducing fraud

As provisions of the Affordable Care Act take hold, states are striving to prepare for the impact a 15%+ increase in enrollments will have on their operations. This fuels an elevated need to streamline program enrollment and operations while also continuing to bolster resilience to fraud. By strategically adding innovative systems to manage identity, public organizations can achieve both goals.

Boosting efficiency and goal-oriented service

MorphoTrust, the U.S. leader in identity solutions and services, and verification technologies to state, federal and local government, can help agencies meet the demands of new health care regulations by designing and implementing end-to-end solutions. These systems are uniquely capable of linking the physical beneficiary with identity records already trusted by the state (i.e. driver's license data) to open up new applicant channels. Those same capabilities bring reciprocal opportunities to accelerate processes and mitigate fraud risk at the point of service.

For example, health agencies can leverage MorphoTrust technologies to automatically verify the identities of applicants via new self-service channels of delivery. The result is applicants can enjoy easier, more convenient access to program benefits while agencies continue to operate in a secure manner. Further, case professionals can focus on their mission to address the health needs of clients rather than spending unnecessary time on administrative tasks, such as identity checking. When fully leveraged beneficiaries enjoy high service levels, your staff is able to focus on other, high-value activities, with protections in place to curtail the possibility of fraud.

With self-service options for applicants, agencies can speed enrollments via a mobile phone app, tablet or kiosk. By leveraging these now ubiquitous platforms it is entirely likely the need for applicants to wait to see case workers could be greatly diminished or even eliminated. Successfully employing these new capabilities means the time needed for applicants and case workers to interact can be focused on the delivery of critical services.

Continuing the Trend of Fraud Mitigation

By offering applicants faster enrollment options, health care agencies and providers also benefit from the most reliable information to verify identity and eligibility. MorphoTrust technology uses digital watermarking to authenticate driver's licenses and identity cards while also employing other proven technologies to ensure people are who they claim to be.

MorphoTrust builds and delivers innovative solutions that integrate with a state or agency's existing systems and infrastructure, such as facial image analysis, motor vehicle agency (MVA) records and master data. The use of digital watermarking technology encrypts/decrypts data within intelligent card solutions to instantly authenticate identity-related documents, and verify many other important details important to caregivers and beneficiaries.

SAFRAN MorphoTrust USA

To learn more, visit **morphotrust.com**

Reliable Data to Measure What Matters

SAS® Claims Analytics for APCD converts big data into insight for better health care decisions.

What if your state could create a transparent health data infrastructure that provides stakeholders with the critical information they need to make the best health care policy decisions?

States are turning to All-Payer Claims Databases (APCDs) to provide visibility into the cost of health care services. The purpose of APCDs is to help stakeholders — including state leaders, legislators, constituents and others — to understand and identify variation in payment and quality across health care plans and providers to promote informed decision-making across the entire health care system. However, without the proper tools, assimilating this massive amount of information can result in an unwieldy data heap that makes it difficult to draw meaningful conclusions.

Enter SAS Claims Analytics for APCD, an innovative solution that compiles claims data from multiple payers, prepares it for advanced analytics, and delivers meaningful insights to stakeholders — from policymakers to consumers. States and agencies can use the solution to access built-in health care metrics and even create custom analysis and research based on the APCD information.

Specifically, SAS Claims Analytics allows states and agencies to:

- **Better manage health care data**
  Create a comprehensive health data management process that makes it easy for payers to submit their claims in a secure manner and provides a data preparation process that organizes the claims for the types of analytics that states need to do.
- **Provide visual data analytics of health care information**
  Explore and utilize *all* of the data, rather than a sample, to generate health insights that are important to your state.
- **Deliver meaningful insights about the health care system to citizens**
  Create a consumer Web portal that displays information to your constituents. Create easy-to-use reports and visualizations that provide drill-down capabilities to deliver insights that are most important to citizens.

sas®

For more information about how an All-Payer Claims Database can provide a platform for transparency and innovation, visit **sas.com/apcd**

Symantec: Helping organizations tread carefully when securing electronic health information

As states move to roll out the Affordable Care Act (ACA), healthcare agencies are rapidly adopting secure information exchanges (SIEs) to allow easy transfer and access of electronic health records.

But if they can't effectively protect sensitive patient data from prying eyes, everyone suffers. Consider these recent breaches:

- **A state department of technology services director was forced to resign** after a hacker compromised weak user authentication to steal Social Security numbers and other personal data of about 260,000 Medicaid recipients, costing the state approximately $10 million to remediate
- **An additional 6,000 state Medicaid beneficiaries were exposed** when a third-party claims contractor saved the information to an unencrypted thumb drive that was later lost
- **A former state employee was arrested** for swiping the personal information of more than 228,000 Medicaid recipients
- **A state was required to make a $1.7 million payout** after a hard drive was stolen containing Medicaid beneficiary information
- **A state misplaced a USB drive** containing PHI for 280,000 Medicaid recipients

In an era of growing cyber threats, even inadvertent data loss can result in millions of dollars in fines under HIPAA regulations, which has become more stringent as a result of HITECH and the FINAL Omnibus Rules. Additionally, it can take years for healthcare agencies to rebuild constituent trust — and their reputations — following a data breach.

What agencies don't know can hurt them

To protect their interests, Symantec believes organizations must commit to a failsafe approach when building SIEs. Symantec recommends that government and healthcare organizations:

1. **Aim for a 360-degree security method:** Relying on strong user-authentication that includes back-end identity verification can ensure that only authorized users can access data. Adding often overlooked front-end monitoring to detect fraudulent activity can bolster the solution.
2. **Create centralized control:** Incorporating a cloud-based data loss prevention (DLP) program can provide a highly effective single point of control. As more information moves into the cloud, it often resides in multiple environments and locations. A DLP can help organizations avoid the ensuing logistical nightmare, and weakened security.
3. **Encrypt the data:** Taking this extra step to protect information in the DLP cloud can help make protection systems as close to failsafe as possible.
4. **Add antivirus protection:** Once the data is secure, relying on anti-virus monitoring can thwart phishing, malware and other dangerous attacks or breaches.
5. **Include e-Discovery:** In case of an attack, tapping this component provides crucial information to aid breach or fraud investigations. E-Discovery maintains audit trails that reveal who accessed the data, for how long and whether violations occurred.

A strong defense requires a multi-layered strategy. To learn more about how Symantec can help health organizations and government agencies roll out SIEs securely, visit **http://symantec.com/healthcare** or read the white paper, "New World Order: Effectively Securing Health Care Data Through Secure Information Exchanges at http://eval.symantec.com/mktginfo/downloads/securing-healthcare-data-through-secure-information-exchanges.pdf.

Symantec™

Infosys® Public Services | Building Tomorrow's Enterprise

Building Tomorrow's Health and Human Services

HHS organizations are in a balancing act: Comply with a range of mandates including healthcare reform while transforming to become more citizen-centric and integrate health and social programs.

Infosys Public Services partners with HHS organizations to help them stay ahead of the innovation curve.

Optimizing operations today while building tomorrow's enterprise

Regulatory Compliance: HHS organizations need to shift focus from compliance to care and service. Our future-proof solutions for Health Exchanges, eligibility, modernization, ICD-10 transition, and other imperatives enable HHS organizations to quickly adapt to evolving regulatory requirements and connect health and social programs at lower cost and risk.

Connected, Smart, Agile: HHS organizations need to connect with citizens to improve service delivery, become smarter with better decision making, and optimize operations and costs. Our solutions are architected to utilize cloud, mobility, social media, analytics, and other disruptive technologies to address these imperatives and improve mission outcomes.

Distinct solutions delivering value with excellence

Insights from a broader perspective: Our consultants apply best practices from across industries to innovate 'outside-in' and manage transformation e.g. Affordable Care Act in healthcare, consumer engagement in retail, and fraud detection in banking.

Linking strategy to execution: Our value frameworks like IMPACT™ and VRM, excellence centers, and capabilities across consulting, systems integration, IT and business process services ensure robust implementation.

Culture of delivery excellence: Our proven capability and local + global delivery ensure 98% of projects are on time and deliver business value with predictability.

Compliance:
Healthcare Reform and Mandates
- Health Benefit Exchange
- iTransform™ for ICD-10
- EHR Interoperability and Integration

Connected:
Engage Digital Consumers
- Mobile Government
- SocialEdge™ Social Media Platform
- Disease and Wellness Management

Smart:
Leverage Insights and Innovation
- BigDataEdge™ Big Data Analytics Platform
- AssistEdge™ Customer Service Platfom
- Hospital Performance Management

Agile:
Optimize Operations and Costs
- Cloud Ecosystem Hub
- IT Modernization
- Shared Services

For more information, contact askus@infosyspublicservices.com www.infosyspublicservices.com/hhs

ENABLING DATA-DRIVEN MANAGEMENT
OF GOVERNMENT HEALTH AND HUMAN SERVICES PROGRAMS

Optum provides effective business intelligence solutions — a powerful combination of analytics supported by enterprise data warehousing and user-friendly reporting dashboards and tools — to help government health and human services make sense of the data they possess. Our solutions help turn raw data into understandable and usable information to enable fact-based decisions about how program funds are spent, how services are delivered, how well programs perform, and to provide insight into whether individuals are getting the care they deserve.

REAPING BENEFITS

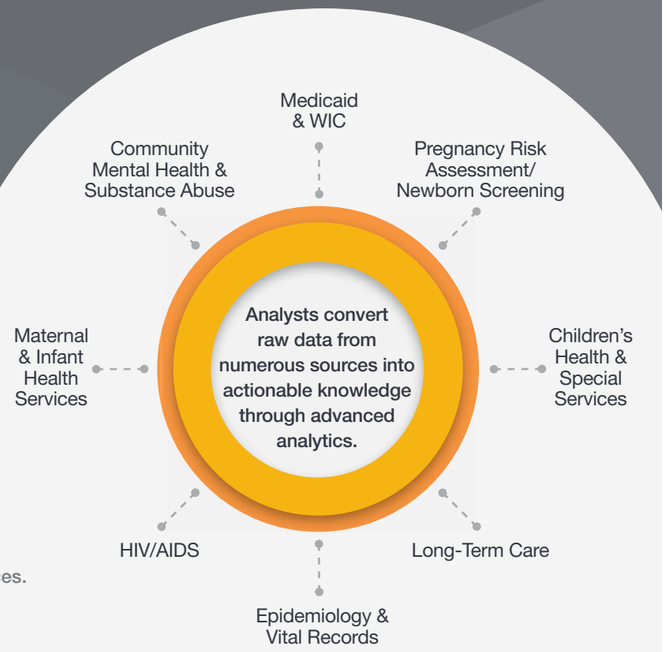
To date, Optum's business intelligence solutions have provided documented cost savings and financial benefits in excess of $3 billion to states across the country. In fact, OptumInsight solutions help effectively manage programs and services that cover one of every four Medicaid recipients—approximately 15 million people.

The state of Michigan's Enterprise Data Warehouse (EDW) links data across multiple sources to enable the sharing of data. Today nearly 10,000 users in five major departments, 20 agencies, and more than 100 bureaus rely on the EDW to do their job more effectively and better serve Michigan residents with health and human services programs, the courts and treasury. Vital activities such as tracking children across state programs, monitoring long-term health outcomes, and clamping down on fraud and abuse are bringing real results. Michigan recently acknowledged to *Forbes Magazine* that the EDW helps save approximately $1 million per business day, or more than $250 million per year.

START NOW

Optum counsels that instead of ripping and replacing existing IT systems, states should begin by working within the framework of the Medicaid Information Technology Architecture (MITA), a national initiative supporting IT modernization. Optum suggests that states:

- Start with a few systems integrated into an enterprise–wide data warehouse, and add additional phases over time.
- Adapt existing systems to a modern, flexible service-oriented architecture.
- Add business intelligence and analytics, and tools such as dashboards for consistent reporting and monitoring.
- Create a governance process that manages data sharing, related conflicts between agencies, privacy and data security.
- Secure the support of the state legislature.



ADVANCED HEALTH CARE ANALYTICS

Health and human service agencies store and process significant volumes of raw data, often from disparate sources. Transforming this data into actionable information drives better decisions, reduced costs and improved health care.

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OPTUM™

Optum is transforming the performance of state and federal government health and human services programs with a broad array of population health services, advanced analytics, and information technology solutions that drive better decisions and results.

To learn more, visit Optum at www.optum.com/government.

Building a Smarter Planet one city at a time.

On a smarter planet, governments promote the economic health, welfare and security of their citizens. Through a unique combination of industry experience and expertise, IBM is helping governments drive transformative change, improve organizational accountability, reduce risk, create a citizen-centered experience and strengthen security and public safety. With years of valued relationships and experience serving all levels of government worldwide, we are equipped to provide end-to-end business and technology solutions to help governments to address some of society's most critical problems.

A Smarter Planet starts with smarter cities.
Let's Build A Smarter Planet.

With solutions such as **IBM Cúram Social Program Management** we can work together on a prosperous future. For more information, visit **ibm.com**/software/products/us/en/social-programs

ibm.com/government

Achieve transformation. Your priority. Our commitment.

When it comes to transforming health IT, a strong foundation matters. Our expert guidance is built on 20+ years of experience delivering complex state, federal and commercial health and insurance programs, including MITA-compliant, COTS-based solutions.

Let us help you achieve a connected network across government agencies, providers and consumers.

- Medicaid enterprise transformation
- Health insurance marketplaces and integrated eligibility
- Data analytics

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