BRIDGING THE DIVIDE:

LEVERAGING NEW OPPORTUNITIES TO INTEGRATE HEALTH AND HUMAN SERVICES

prepared for:
APHSA

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In association with:
APHSA National Workgroup on Integration *(See Attachment A for participants)*

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Attachment A:
List of Participants in the First Convening of the APHSA National Workgroup on Integration in Washington, DC on September 19 and 20, 2011

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American Public Human Services Association

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I. INTRODUCTION

The American Public Human Services Association (APHSA), in an effort to provide support to its members—the leaders of state human service systems—has initiated a project that will develop guidance for states on the horizontal linkages of health and human services along the interoperability/integration continuum. The APHSA *National Workgroup on Integration* is exploring ways in which states can enhance efficiencies and maximize state and federal investments in health information technology, create effective and integrated workflow processes, enhance systems design for full integration, and address other cross-system areas of inquiry identified through the work of the National Workgroup. This guidance will equip APHSA members with the critical knowledge and understanding of this emerging opportunity and will facilitate state implementation efforts toward a modern integrated health and human service system that will improve outcomes for the children, families and individuals they serve and produce sustainable cost savings to both systems in the long run.

Background

Passage of key federal legislation over the past six years has unleashed a significant federal investment in health system improvements, beginning with funding made available through the Deficit Reduction Act of 2005, followed by the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA). Then, on March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act, followed one week later by the Health Care and Education Reconciliation Act of 2010. Together, those two laws are referred to as the Affordable Care Act (ACA). Although earlier investments targeted development of Electronic Health Records, the ACA provisions focus on medical insurance portability and connectivity among private and public coverage offerings, expanded coverage and choices, improved quality of care and reduced costs. The ACA unleashed a flurry of activity to maximize the funds made available through ACA to build modern health systems to support the required new business models, interoperability and data management for the new Health Insurance Exchanges, Medicaid and CHIP (Children's Health Insurance Program).

Every state but one accepted a federal Planning Grant to begin the process of planning and designing their IT upgrades to meet ACA requirements. In addition, six states and a consortium of New England states received a total of approximately $241 million in special "Early Innovator Grants" in early 2011 from the federal Centers for Medicare and Medicaid Services (CMS). These grants were awarded to states willing to lead the way in systems development and able to demonstrate a variety

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of approaches whose core functionalities are replicable and can be adopted and tailored by other states. (It must be noted, however, that two of those states have announced that they will return their Early Innovator Grant money to the federal government.)

Then, as recently as May 2011 and again in August, a new round of federal grants were announced. Sixteen states and the District of Columbia received Establishment Grants totaling $219.4 million to facilitate the process of building the Health Insurance Exchanges they planned. The federal government and states are driving to meet the looming ACA deadlines, most notably: certification of states' Advance Planning Documents (APD) by January 2013, and fully operational Health Insurance Exchanges, including interoperability with Medicaid and CHIP, by January 2014.

CMS has been driving the ACA implementation and systems development but, until recently, did not focus on how to connect more broadly with the other government human services.

Federal Planning Grants

All states except Alaska*

**Florida announced it plans to return the grant*

Early Innovator Grants

Kansas,* Maryland, New York, Oklahoma,* Oregon, Wisconsin and a consortium of five New England States (Connecticut, Maine, Massachusetts, Rhode Island and Vermont) along with the University of Massachusetts

**State announced plans to return the grant*

Establishment Grants

California, Connecticut, District of Columbia, Illinois, Indiana, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, Oregon, Rhode Island, Washington, West Virginia

U.S. Department of Health and Human Services (DHHS) Secretary Kathleen Sebelius has affirmed her commitment to assuring interoperability among the health and human service systems. This summer, the U.S. DHHS Administration for Children and Families (ACF), the federal oversight body for many of the nation's social service programs, along with the U.S. Department of Agriculture's Food and Nutrition Service (FNS), which provides the food assistance programs in the states—also declared interoperability with the new Health Exchanges, Medicaid and CHIP as a top priority and began looking at ways to simplify rules and policies and to help states modernize work processes and their IT systems.

Now, states opting to develop and/or enhance their eligibility and enrollment systems for Medicaid, CHIP and the Exchanges have a unique opportunity to turn their attention to the expansion of their systems to include eligibility screening and enrollment for human service programs, and more. These include, but are not limited to, Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), child care, child support, child welfare, behavioral health, long-term care and other support services.

Innovative human service leaders, however, are looking beyond eligibility and enrollment to explore the possibilities envisioned in a larger, fully integrated health and human service system that goes beyond the interoperability of front-screen data to achieve seamless, streamlined care coordination, relationship management, shared services, and other components of a modern marketplace that is consumer focused and outcome driven.

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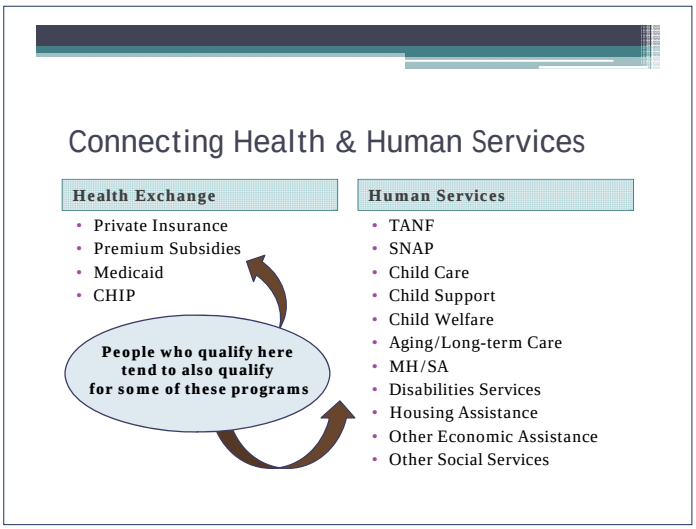
II. HEALTH AND HUMAN SERVICES INTEROPERABILITY / INTEGRATION

Why Integrate?

Many of the same people who qualify for Medicaid, CHIP or some level of premium subsidy identified through the Exchanges also qualify for one or more human service assistance programs.

The positive impact of coordinated care and integrated case management on improving the overall health and well-being of individuals and populations— strengthening families, achieving employment and independence, improving the well-being of children, youth, people with disabilities, seniors and other vulnerable populations—is well documented. Better outcomes mean healthier, safer, stabilized individuals and families with a better chance of sustainable independence from government services and long-term personal success. Better outcomes from the first encounter with a state system also reduce the number of people who return for service, which, in turn, reduces the cost to the state. Coordinated care improves transitions, aligns resources, reduces duplicative effort, increases efficiency and reduces the associated administrative and service delivery costs, as well.



The Affordable Care Act and the accompanying funding available for states to invest in new business process development and information technology for health care offers an unprecedented opportunity for states to leverage that investment toward improvements in their broader government health and human service systems to improve coordination of care, improve client outcomes and reduce costs to the state.

To date, however, the federal Administration and states have been focused on meeting the ACA deadlines for establishing policies, procedures and systems to implement the Exchanges and, with few exceptions, have not yet focused on the interoperability or integration with other government human services.

Government human services like mental health, substance abuse, public health services, employment supports, child care and, in general, human service case management have all been largely unattended to in discussions of modernization and IT enhancements under ACA. The potential for streamlined, seamless eligibility determinations and verifications, at a minimum, simplified enrollment and referrals, and, ultimately, greater coordination of care present the public sector with an opportunity to envision the truly customer-focused, one-stop shop, "service home" often discussed but rarely achieved in the public sector.

Those states that have begun identifying the horizontal linkages are largely focused on data exchange for eligibility determinations, enrollment and status verification processes only, leaving the rich potential for real integration for another day.

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Unlike even a decade ago, today's technology can enable seamless interoperability of data exchange, program coordination, case management and business work flow process, even while maintaining security and privacy requirements. New, enterprise architecture, modularity, web-based designs, cloud computing and all the capabilities of today's technology reduce the need to build, maintain and staff separate systems for program silos. Systems change and IT development, however, take time, and ignoring the potential of cross-system connectivity in early planning at a time of unprecedented restructuring and funding levels is a lost opportunity not only to save on system development costs in the future but to build the foundation for an integrated 21st century health and human service system that will make a difference for generations of Americans to come.

Why Now?

The urgency to engage human services at this early point in the health IT systems development is driven by several key factors:

1. CMS requirements for a new business model, shared services and IT architecture offer guidance for human service redesign;

2. Standardization of health IT core functions, architecture modularity, required interoperability and leveraged re-use, all facilitate human services' access to modernization;

3. Significant yet time-limited federal funding for system planning and design, as well as a time-limited exception to the cost-allocation rules to enable interoperability, offer a short window of opportunity for human service leaders to assure that future linkages are not only possible but planned.

Section 1561 of the Affordable Care Act calls for interoperability of emerging health information technology systems and Exchanges with other health and human service systems. It requires that all new IT systems be scaled larger and promote integration across the entire health and human service enterprise, including private organizations that perform certain business processes, like eligibility determination and enrollment, among others. This section of the ACA, and recent actions by the federal government discussed elsewhere in this report, acknowledge the ACA funding as a stepping stone toward modernization of business functions and technology and lays a foundation for future expansion to full integration with the entire array of health and human services.

This critical section of the law recognizes that individuals and families eligible for Medicaid, CHIP or premium subsidies available to help purchase health coverage through the new Health Insurance Exchanges are also likely to be eligible for at least some benefits and services under the states' human service programs.

Beyond the law, the demographics and statistics associated with both the health and the human service systems make a compelling case for supporting interoperability and integration. Consider: The changes effected through the ACA mean millions more people will be eligible for Medicaid in 2014; an aging U.S. population means the need for even more medical and social services; government retirements and, in these critical fiscal times, layoffs mean fewer workers to do business as usual, which presents a good opportunity to automate and update; and, given the percentage of Medicaid-eligible people who receive other social services, it just makes sense to integrate. Interoperability with the new systems is, therefore, both important and inevitable for a modern, 21st century government health and human service system. Integration is the logical next frontier.

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VALUE PROPOSITION: THE INTEGRATION OF HEALTH AND HUMAN SERVICES

Human Services leaders have long recognized the bio-psycho-social intersection of health and human services in vulnerable populations, the major consumers of government programs. A significant number of people served in Human Services programs are also covered by government health plans, like Medicaid and CHIP. Like healthcare, the nation's Human Services System is on an unsustainable course of rising costs and growing populations, aggravated by a weak economy that cuts resources even while overwhelming the safety net.

Integrating healthcare and human services plays a key role in lifting people out of poverty, improving health and enhancing employment possibilities for the people served by both systems. A new body of knowledge generated within the past ten years indicates that improved care and service coordination and timely access to critical information for decision making across the Health and Human Services Systems has proven to produce better outcomes for the individuals coming to the health and human services doors. When integrated, both systems are able to efficiently transition consumers to the right level of service and reduce returns, which, in turn, reduce the cost to the state both in the short- and long term. Better outcomes mean healthier, safer, more stabilized individuals and families with a better chance of sustainable independence from government services and long-term personal success.

A robust, integrated Health and Human Services enterprise is possible through modern information technology and should be the hallmark of the modern consumer experience. Aligning a Human Services business model of shared services, streamlined business functions, interoperable information systems, care coordination, relationship management, and outcomes reporting with the new Health System experience is essential to achieving the desired improved outcomes for individuals and cost savings for the state. That alignment begins with envisioning the Human Services System of the future, and planning for the connectivity to healthcare now.

New time-limited federal funding encourages states to plan and develop system connectivity between healthcare and human services. The Affordable Care Act (ACA) of 2010 provides significant resources for states to reengineer business processes and embrace 21st century technology to create a modern marketplace for health insurance and health information management. In August 2011, the federal Administration enacted an exception to federal funding rules to encourage states to leverage ACA resources to develop information linkages between their Health and Human Services Systems. This means that state Human Services leaders now have access to ACA planning and implementation resources to initiate the development of connectivity to the Health Services systems in their states. The nature of these time-limited funds drives a sense of urgency to begin the process now.

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III. A SPECTRUM OF POSSIBILITIES

Definitions

The terms *interoperability* and *integration* are not interchangeable. It is important to understand the distinction between them and the context in this discussion.

Interoperability is the ability of a computer system to operate reciprocally, that is, to run application programs from different vendors and to interact with other computers across local or wide-area networks regardless of their physical architecture and operating systems, usually achieved through hardware and software components that conform to open standards, such as those used for the Internet[1]. *Interoperability* is essentially the data exchange capability of modern information technology.

Integration, however, is the process of attaining close and seamless coordination between or among systems, departments, programs, et cetera[2]; in the human service context, full *integration* means a holistic approach to serving each consumer, using the interoperable data exchange to link the people, services and information across systems and programs for robust care coordination, integrated case planning, timely service delivery, and cross-system relationship management.

It may be helpful to think of *interoperability* on one end of a continuum scale and *integration* at the other end. Within that continuum, there is a full spectrum of possibilities to blend, braid, connect, coordinate and integrate programs, services, workforce, administrative functions, funding and more across the entire health and human services enterprise. Some states and localities have made significant progress toward integrating within certain areas of their human service systems, but none have yet to link to the new health IT systems being developed through the Affordable Care Act.

The Integration Vision

To achieve a true integration of state health and human services systems will take vision and significant action to realize the vision. The APHSA National Workgroup on Integration began with the notion that a broad vision for an integrated system might be that of a fully integrated health and human services system that will operate a seamless, streamlined information exchange, have shared services and coordinate care delivery in a consumer-focused modern marketplace experience and will improve consumer outcomes, improve population health over time, and bend the health and human services cost curve by the year 2025.

The Integration Vision

A fully integrated health and human services system that operates a seamless, streamlined information exchange, shared services, and coordinated care delivery that is a consumer-focused modern marketplace experience designed to improve consumer outcomes, improve population health over time, decrease poverty, increase employment possibility and, ultimately, bend the health and human services cost curve by 2025.

[1] *www.businessdictionary.com*
[2] *www.businessdictionary.com*

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At the core of an integrated health and human service system are a few key principles: person-centered, strengths-based, individualized and integrated case management, ease of access, care coordination, appropriate services available in natural settings, streamlined, data rich, and performance driven systems. How each state approaches and achieves system integration will be as different as the unique characteristics and needs of each state.

As lessons from ACA planning have demonstrated, there is no *one way* to make it work. However a state chooses to fashion its integration design, the goal is a coordinated "system" that works for the consumer, produces positive results and reduces costs to the state. At the nexus of government health and human services are the ACA-driven technology developments that enable the linkage between private insurance, government coverage (Medicaid and CHIP), and the sliding scale premium supports up to a certain income level. These improvements facilitate eligibility in the appropriate insurance plan in a seamless way that is invisible to the consumer, creating a modern marketplace for health insurance coverage.

Although the Exchanges are focused on health insurance and are not intended to be social service portals, it is possible to envision them operating like a modern marketplace experience with linkages to human services to help those who qualify see and learn more about social services that may be helpful to their overall health and well-being and, eventually, to manage their total health and human service experience in one place.

This vision is grounded in the research on the social determinants of health as well as the health determinants of an individual's social condition. For example, chronic medical conditions can often prevent sustainable employment, which often leads to relying on government support services such as TANF, SNAP, housing and others. Conversely, inadequate housing, nutrition and household income often lead to deteriorating health, resulting in chronic medical conditions like hypertension, obesity, depression and other serious medical issues. The Human Services system could benefit from a richer "health home" model evolving from the health care reform efforts in order to get a fuller picture of individuals and families that cross health and human service systems.

To move beyond the interoperability of eligibility data to full system integration demands attention to reengineering government human services in order to embrace new business models that are customer focused and customer driven; common business rules that reduce administrative burden; shared services that cross silos; modern technology that supports integrated service delivery and data management; and organizational culture change that reorients the workforce toward holistic service and cooperation.

The ***core principles*** of an integrated health and human service system reflect the components of a consumer-driven business model and the philosophical grounding of the *Systems of Care* approach to service delivery. Both approaches are grounded in a positive consumer experience, producing improved outcomes for the consumer and reduced cost to the state.

The core principles include: a consumer focus; online, self-directed, easy access; online navigators; seamlessly coordinated across systems and programs; care teams; one-stop shop; single, streamlined application; accurate, timely, real-time response; easy identification of short-term, immediate needs to more easily refer and enroll; total relationship management; a common language; reduced administrative burden; integrated business processes; real-time data analysis and management tools; security of privacy and confidentiality; and data analysis for managing population health outcomes and social outcomes.

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Shared services save money and time behind the scenes but also can mean a quality customer experience. Some examples include: web portal/single point of entry, coordinated business rules and operations, interfaces to federal databases for data verification, case notes and notifications, privacy controls and managed confidentiality with multi-layered access, workforce training, real-time technology systems, trusted information sharing, combined/coordinated funding stream, and integrated care teams.

The Benefits

The benefits of an integrated system extend to both the customer experience and to the state's financial experience over the long haul. Some benefits include: Better health and well-being outcomes, the ability to signal prevention and early intervention services/minimize need for costly, acute care, individualized and integrated health and social service plans, improved coordination of the range of services, reduced return to service, reduced cost of readmissions, reduced length of stay, reduced administrative costs, improved operational efficiency, shared technology systems/reusable software, better data for decision-making, reduced fraud and improper payments, and better data for more accurate population-based service planning.

The Challenges

Although the ACA planning and implementation efforts have provided numerous lessons and guidance for the health sector that can be applied to the human service sector, the barriers to doing so loom large. For one, the people tasked with ACA implementation are generally health and insurance professionals (Medicaid directors, private health insurance network personnel and health information technology experts), not human service professionals and are, therefore, neither knowledgeable about nor focused on meeting the needs of human service consumers. Their focus is driving the work to meet the ACA deadlines that are fast approaching. In addition, federal funding to date has been exclusively for health care reform efforts and health IT, and the nation's fiscal environment has dampened state spending on anything but the essentials. Confusing and restrictive cost-allocation requirements at the federal level contribute to the challenge of true integration, although recent announcements by the federal administration will relieve some of that burden (discussed later in this report).

Most commonly raised as significant challenges are the differing eligibility requirements at the federal and state levels, complex data-sharing rules, complex confidentiality rules in different systems, legacy technology systems in human services that are antiquated and increasingly unsupported and political will. Lastly, in most states, the magnitude of ACA implementation is such that a discreet group of people are working on it and the lack of knowledge about it in the human service sector is pronounced, even at the highest levels.

Nevertheless, some innovative human service leaders have seized opportunities within their states to integrate logical systems, break down silos, and define a vision of the future toward full integration. The challenges they describe generally fall into seven categories:

1. Governance
2. Administration (business rules, standards, work flow, etc.)
3. Infrastructure (organizational structure, facilities, workforce, etc.)
4. Technology
5. Practice / Service Delivery
6. Policies and Regulations
7. Politics

The APHSA National Workgroup on Integration will explore each of these areas in depth over the coming months and will offer guidance to states wrestling with these challenges as they move toward interoperability and, ultimately into integration of their health and human services systems.

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IV. WHAT WILL IT TAKE TO INTEGRATE HEALTHCARE AND HUMAN SERVICES?

To build a 21st century health and human service system that is person-centered, integrated, and performance driven, the sector must learn from the states that have begun the journey and build on the experiences of systems' change evolving from the ACA implementation.

APHSA convened the National Workgroup on Integration to synthesize current work in this area and create guidance for states. Areas requiring attention identified so far include: logic model, vision, governance design, workforce competencies, technology issues, cost-benefit analysis, implementation process, organizational culture change, new performance measures/measures of success, funding and political will.

Sustainable solutions for effective and efficient interoperability and integration will require an operating framework that enables the exchange of information, captures and analyzes events, triggers actions on the individual customer level and on the broader organizational level to facilitate planning, management and outcome measurement for the individuals, for populations, and for the agency. To really maximize the opportunities that a truly interoperable/integrated system presents, states must:

1. Understand the drivers of systems integration (why do it)
2. Reach across organizational boundaries
3. Engage multi-disciplinary stakeholders
4. Build a roadmap
5. Connect to and leverage local efforts
6. Identify short- and long-term benefits
7. Spread best practices

APHSA's role is in the forefront of advocacy on the state and federal levels for flexibility, support and resources; to assist states with planning, guidance and technical assistance; and to monitor development in both the ACA and interoperability/integration of health and human services. APHSA will also provide information and support, build a network of early adopters for information exchange, and help other states get going.

The Role of the Federal Government

For a number of years, the USDHHS Administration for Children and Families (ACF) has been working with states to create a conceptual Human Services Information Architecture (HSIA) to produce a technology framework and standards that would result in shared components and shared services among state human service program systems. The goal is to create an environment and infrastructure that would match state and federal data for verification, reuse eligibility information, allow people to put eligibility information online, and notify clients when government data indicate that they are eligible for a certain program.

ACF engaged the Johns Hopkins University School of Public Health and Applied Physics Laboratory to leverage past development of various federal and state programs, including Medicaid Information Technology Architecture (MITA), National Information Exchange Model (NIEM), Global Reference Architecture (GRA), Service Oriented Architecture (SOA), and cloud computing to develop the **National Human Services Interoperability Architecture (NHSIA)**; but it will take time to complete.

ACF has also taken the lead for a ***new Human Services NIEM domain***. The National Information Exchange Model (NIEM) was

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launched in 2005 by the U.S. Department of Homeland Security and the U.S. Department of Justice to streamline information sharing between organizations in emergency situations and in day-to-day operations. In 2011, the U.S. Department of Health and Human Services joined the NIEM network as Domain Steward for both the Health Domain through the Office of the National Coordinator and for developing the new Human Services Domain through ACF, thereby creating a mechanism for seamless information exchange among federal, state, local and tribal agencies. The Human Services Domain includes TANF, SNAP, Medicaid, Child Welfare, and Child Support. This work will enable the seamless exchange of data across these state and federal programs and facilitate a state's efforts toward both individual and global data management, from an integrated case plan to population-based service planning. In addition, for the past nearly two years, ACF has also been working with a consultant to support internal culture change and help ACF employees understand and connect to health reform implications for human services. This work includes helping to make the connections between the NHSIA and the NIEM.

In July 2011, ACF released a resource guide titled ***"Your Essential Interoperability Toolkit: An ACF/HHS Resource Guide"*** (referred to as the ACF Toolkit) to assist state human service agencies to "connect with their health counterparts to maximize Affordable Care Act benefits." The Toolkit is described as a "compendium of interoperability policy, funding and technology documents to: improve outcomes for your clients; enhance your agency's operational efficiency; save money, lower costs and reduce improper payments."[3] It contains federal policy letters, memoranda and executive orders, as well as information about the ACA Section 1561 recommendations, new rules for the Advance Planning Document process, enhanced funding opportunities under ACA, and descriptions of work on human service information technology that ACF is conducting. ACF expects to continue to develop and make more resources available that states can tap into for technical support, questions and strategy development as they move forward with developing the enterprise architecture needed to accomplish the goal of interoperability.

Leadership in this federal administration has been clear and frequent regarding their commitment to interoperability and integration between health and human services.

It is important to note that the U.S. Department of Agriculture, Food and Nutrition Service (FNS) is a key player in this work, as FNS is the federal agency with oversight of the Supplemental Nutrition Assistance Program (SNAP), a major service and support for economically challenged families. FNS has joined ACF and CMS in pronouncing that agency's commitment to interoperability across all health and human service programs.

Leadership in this federal administration has been clear and frequent regarding their commitment to interoperability between health and human services. In spring 2011, the administration issued a joint letter signed by directors of ACF, CMS and FNS urging integration. Then, in late spring 2011, CMS issued the **Seven Conditions and Standards** that must be met for certification of an Advance Planning Document. Condition No. 7 is *interoperability.* The **Interoperability Condition** acknowledges and encourages leveraging the significant investments being made in Exchanges, Medicaid and CHIP to benefit other human service eligibility systems.

[3] ACF Toolkit

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The OMB A-87 Exception

On August 10, 2011, the Administration released **a Specific Exception to OMB Circular A-87 (Section C.3)** that clarifies funding opportunities and encourages the horizontal linkages between health and human services. This A-87 Cost Allocation Exception is important because, under ACA, each health program pays its own way for systems development; however, this exception allows the planning and development of horizontal linkages between Health Insurance Exchanges and the Human Services Systems without a required cost share. This is great news for states that are interested in connecting healthcare and the human services to create that modern customer experience in government programs.

> The A-87 Exception is good news for state Human Services. It eliminates the funding complications and the barrier to having Human Services at the ACA planning and implementation table.

Here's how it works:

Under the ACA, systems development costs are covered by the federal government at 100 percent FFP (federal financial participation) for Exchanges, at 90/10 FFP for Medicaid, and at administrative funding levels for CHIP. The Seven Conditions and Standards, as well as any grant conditions, must be met to receive this enhanced funding. But it is time-limited.

States may receive enhanced 90 percent FFP for design, development, installation, or enhancement of eligibility determination systems through calendar year 2015. The APD must affirm completion by December 31, 2015, and costs for goods and services must be furnished by that date as well. After that, the enhanced FFP of 75 percent applies to maintain and operate Medicaid systems that previously qualified for 90 percent FFP. States that have already invested in improvements that would have qualified for the 90 percent FFP may be eligible for the enhanced 75 percent for maintenance and operations prior to December 31, 2015 if they continue to meet the requirements, standards and conditions for the enhanced funding. States that do not wish to receive enhanced funding can receive 50 percent FFP for systems developed, installed, or enhanced after calendar year 2015 and continue to receive the 50 percent FFP for maintenance and operations.

The A-87 Exception allows a Specific Exception to OMB Circular A-87's cost allocation regulations that require other benefiting programs to participate in sharing common costs in IT systems development. The Exception removes that cost barrier from Human Services Systems interested in leveraging ACA funding and system improvement activities, although it does require states to provide certain specific assurances around meeting ACA deadlines, allow close federal supervision, and act within a limited time period. The Exception will remain in effect through 2015.

Specifically, the A-87 Exception waives the requirement for cost allocation to other health and human service programs for costs that would have otherwise been incurred for development of the Exchange, Medicaid and CHIP systems, even if other health and human service programs will later build on their foundation. However, if specific requirements for other health and human service programs are added, the incremental costs of adding those requirements must be allocated to the benefiting program. States must track the incremental costs beyond the needs of the Exchange, Medicaid and CHIP, and states must agree that the ACA requirements and deadlines will take top priority and that proceeding under the A-87 Exception will not impede progress

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toward the ACA implementation deadline of live Exchanges on January 1, 2014. The A-87 Exception applies until December 31, 2015, which aligns with the flexibility recently allowed by CMS for APDs in significant progress, but not yet certified, by the January 1, 2013 deadline.

The A-87 Exception is good news for state Human Services. It eliminates the funding complications and the barrier to having human services at the ACA planning and implementation table, which offers the opportunity to participate in early stage developments that could otherwise make future integration impossible.

Clearly, additional guidance from the federal agencies will be required for states to operationalize and optimize the opportunity presented by the A-87 exception. Specifically, states need clear definition of which shared services are allowable under the exception.

The APHSA National Workgroup on Integration has developed a list of shared services that they believe are potential candidates for inclusion in the A-87 Exception; they are:

- Appeals Process
- Case Management
- Client Index (Identifier)
- Client Portals
- Data Warehouse
- Development Team & Architects
- Digitization of Case Records
- Document Generation
- Enterprise Framework
- Exchange Infrastructure (Interfaces and Centralized Interconnections)
- Framework & Infrastructure Support
- Governance
- Interfaces to Community Organizations and Partners
- Interoperability of Eligibility Screening
- Modular or Federated Rules Engine
- Real-Time Medicaid Eligibility Determination
- System Integration
- Workflow Management Tools

APHSA shared this list with federal leadership in ACF, CMS, and OMB and offered to work with them to finalize an official list that fits both the needs of the federal government and those of the state agencies trying to implement these rules. APHSA's request on behalf of the states recognizes that Exchanges and enhancements to Medicaid eligibility systems are currently occurring across the country and that, without the information necessary to maximize the building of interoperable systems, states may miss the opportunity to fully utilize the historical exception provided by OMB to the cost allocation.

Actions States Can Take To Get Started

As with any organizational evolution, integrating health and human services will take time and commitment to the change. At the first meeting of the APHSA National Workgroup on Integration, a panel of state representatives related some of the key readiness factors that will impact success of the integration journey.

The most commonly cited success factors were: the importance of leadership, or a real and visible commitment from the top (i.e., governor); stakeholder engagement; program transformation and service reengineering to facilitate care coordination; a real focus on a consumer-centered, individualized, integrated approach; no wrong door/one-stop shopping; ease of access; multi-agency service and benefit delivery; and the importance of changing the organizational culture to minimize or eliminate silos and encourage a real customer-service orientation.

The journey begins with learning about the state's ACA planning and implementation and deciding whether to leverage the ACA funding through the opportunities created by the recent OMB Exception to Circular A-87.

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TEN STEPS TO GET STARTED NOW

1. Get a seat at the ACA implementation table and use the information in this report to start the conversations, especially the new federal funding opportunity

2. Secure commitment from the Governor by articulating the vision and aligning ACA implementation champions behind the vision

3. Understand the current business model in Human Services and what must change to align with the modern marketplace experience being developed in the health sector

4. Open communications with the federal government in order to negotiate any barriers and seek flexibilities and opportunities to innovate

5. Engage champions at the highest levels to keep the focus on interoperability, at a minimum, and planning now for full integration for the future; develop a mechanism for shared governance and accountability

6. Engage stakeholders throughout the health and human services enterprise to fine-tune the vision specific to state population needs

7. Begin the process of culture change to minimize program and administrative silos and to encourage a culture of sharing, cooperation, coordination, communication, and customer service

8. Assess current human services IT systems for connectivity capability to HIX and prepare a plan to upgrade as needed

9. Assess current capability to provide cross-system and multi-agency service and benefit delivery and care coordination; plan for program transformation and service reengineering as needed

10. Gather and use national and state-specific return-on-investment data, outcome performance, and cost efficiencies to strengthen the logic model for integration

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V. THE LANDSCAPE

Most state human service leaders recognize that it is more than health care that keeps people healthy. Personal safety, job security, adequate nutrition, safe child care and senior care – these, among other social conditions, affect the health and well-being of individuals and families. Recent activities and the A-87 Exception provide an incredible opportunity for government systems to streamline and modernize across health and human service programs and to consider some innovative approaches beyond interoperability of eligibility data.

All of the states are in different places in their journey toward integration either within the human service sector or linked with the health sector. Some states are building two parallel systems; some are trying to build a common platform for everything; and some are in very early stages of planning. Below are just a few examples of states who are further along in their approach toward systems integration.

Utah is one of only two states with an existing Health Insurance Exchange (HIX) designed to help people navigate the state's commercial insurance marketplace (Massachusetts is the other state with an established HIX). Utah also has a very robust modern eligibility system and portal for human service programs, as does Massachusetts. The questions for states like Utah and others who are further along in development of modern business models and information technology systems in both their healthcare and human service systems center on how their existing systems align with federal requirements, what they would have to do to accommodate the large number of people expected to be accessing the HIX after 2014 and, perhaps most importantly, whether they will need to decouple Medicaid and CHIP from their Human Services IT system that they worked so hard to connect in order to incorporate Medicaid and CHIP into the HIX as required under ACA. Like many states, Utah's plans are hampered by the lack of information and clarity about what the federal HIX will look like and how much flexibility states will have before they can make decisions that will impact their functioning Exchange and Human Services system for the future.

Maryland, too, is grappling with this decoupling question, though that state has started down a path of integration. An Early Innovator Grant state, Maryland views health care reform as a stepping stone for modularization and modernization of key business functions. They are maximizing the 90/10 enhanced funding for health system improvements to lay the foundation for incremental modernization of their eligibility system and to build the framework for future growth to include other human services programs. Maryland's strategy is to avoid separating health from human services and thereby creating another silo; rather, Maryland's strategy builds on existing investments and supports a "no wrong door" concept and integration for the long term.

Specifically, Maryland is leveraging technology investments to build a case management and workflow application that provides a communication and management layer between systems for interoperability and integration, data analytics and predictive risk modeling, call centers, and self-service for enhanced consumer experience. Their Business Process Management System, designed for integration and visibility, prioritizes and routes tasks automatically, guides users through decisions, standardizes processes, leverages data from existing systems, externalizes rules for maintainability, and provides real-time visibility and process control. The benefits: significant reduction in manual activities and the associated time and costs, faster accurate decisions, and proactive case management.

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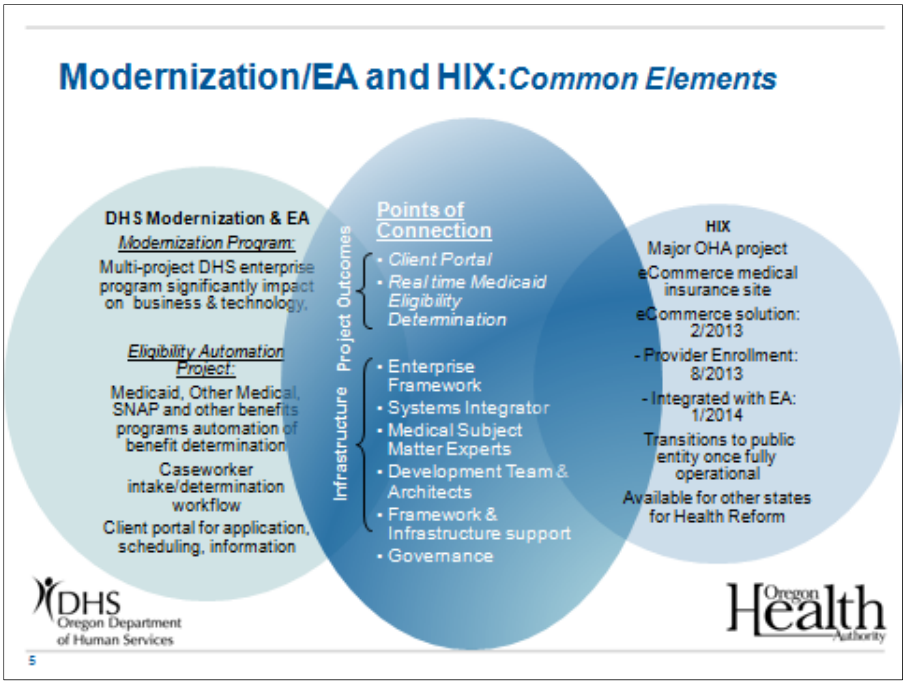
Wisconsin, another Early Innovator Grant state, also has robust IT systems in place and is working hard to develop an HIX that will perform high level eligibility determinations for human service programs. Like many states, however, their goal at this point is to operationalize a functional Exchange. For Wisconsin, many questions remain, including whether leveraging the federal ACA dollars will require building two distinct systems, whether managing a combined system will present cumbersome governance, workforce, and accountability challenges, and whether the current economy will inhibit funding the state share.

Oregon, also an Early Innovator state, has been working to develop the horizontal linkages between their Health Information Exchange and a modern eligibility automation project in Human Services by identifying the common elements between those sectors that can be leveraged to enhance both systems, while assuring adherence to CMS requirements and timelines. The chart below describes where the State of Oregon sees the *points of connections* between the Oregon Health Authority's Exchange and the Department of Human Services Modernization Program designed to upgrade business processes and technology to deliver a modern customer experience for the people served in both systems. Oregon leadership has been working closely with the federal government to negotiate barriers specific to federal human service programs, and they have not been afraid to challenge their own state policies and regulations in their drive toward interoperability and, eventually, integration.

Washington State recognizes that both healthcare and human services are on an unsustainable course of growing populations requiring more and more services and untenable costs. To bend the cost curve, that state's leaders believe that the common impacts needed are decreasing poverty, improving health, and increasing employment and education success for vulnerable populations, who are most likely served in multiple systems. Interoperability within the health and human services sectors is not a new idea for Washington State. The Department of Social and Health Services has adopted a clear, cross-agency vision and orientation toward



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early child development, person-centered, family-focused and strengths-based service delivery. They developed a strategic framework that governs how they want to work, trained staff at all levels, developed a client hub that demonstrates all connections of a client to any program in health or human services, addressed policies and governance issues, and built commensurate business systems and information technology to help them do the work. They created an online portal, built with foundation funds, designed to facilitate public access and enrollment, and are developing in partnership with the Health Care Authority a new prototype for a person-centered health home for vulnerable populations, the largest and most resource-intensive consumers of public health and human services.

New York City represents some of the unique challenges of large cities and county-administered states, where responsibility for health and human services eligibility determinations, enrollment and referral lies at the local, not state, level. ***HHS Connect***, New York City's access portal, is considered a model integrated system for real-time screening, eligibility determinations and referral for the City's health and human services programs. The HHS Connect Worker Portal enables workers to see documents online across service streams to facilitate care coordination for multi-involved individuals. *"HI-Link,"* the City's online health insurance marketplace, provides eligibility screening for Medicaid eligibility and referral to the Medicaid portal for more information and enrollment.

The unique challenge for cities and counties like NYC is determining their role in the ACA-driven changes at the state and federal levels, whether federal funding can be accessed for enhancing their systems that play such a pivotal role in access and service for millions of citizens of their states, and whether the new federal regulations will negatively impact the significant progress they have already made in meeting the needs of citizens of their city or county.

What all of these jurisdictions and others with work in progress acknowledge is the requirement of strong leadership from the highest levels – i.e., Governor, Mayor – to envision a future, plan strategically, and stay focused on the end goals of improved service to and outcomes for the individuals in both systems and the resulting reduced costs to the state. They also acknowledge that the OMB A-87 Exception opens new doors for federal funding opportunities to build the horizontal linkages between health and human services that will minimize the need for state investment in costly IT upgrades or development, and will ultimately help to achieve the integration vision for 21st century service systems.

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VI. PATH FORWARD

The APHSA National Workgroup on Integration has begun the process of investigating areas of inquiry and gathering data that will aid in the development of guidance for states wishing to explore the next frontier of systems integration. The goal is to assure that, as the nation advances toward a modern health care system, the state's human services systems do not get left behind.

APHSA staff and members will continue to be a strong advocate for state Human Services Systems in the role as liaison with the federal government and other key players in this emerging challenge of systems integration for the 21st century. APHSA will continue to update members on progress of the National Workgroup on Integration and will provide consultation and support for states and localities through information sharing and peer-to-peer conversations as needed.

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VII. RESOURCES

Additional resources will be added as discovered in the research and as determined by the National Workgroup on Integration.

www.ACF.Toolkit@acf.hhs.gov—"Your Essential Interoperability Toolkit, An ACF/HHS Resource Guide"

www.adminflexibility.gov – Federal website to collect comments on states' needs for flexibility in federal programs

www.cms.gov/Medicaid-Information-Technology-MIT/downloads/exchangemedicaiditguidance.pdf—the federal "Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0"

www.Exchange.utah.gov—click History, look for Reference Documents toward the bottom, then the New Medicaid Eligibility Study, a recently completed study of what needs to be considered and what needs to be done for Utah to combine their Exchange and their unified eligibility system; may be helpful for other states

www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicaid-eligible-determination-and-enrollment-activities -- Federal Register website with the final rule published on April 19,2011 providing guidelines for federal funding for Medicaid Eligibility Determination and Enrollment Activities

www.healthcare.gov **–** Website designed to help understand the ACA, provides timelines, and acts as a resource for implementation

www.healthcare.gov/partnershipforpatients—John O'Brien, CMS Partnership for Patients, CMS Innovation Center: ACA Section 3021—opportunities; ACA Section 3026 Community-based Care Transition Program (CCTP)

http://healthit.hhs.gov/portal/server.pt/community/hit_extension_program/1495/home/17174 **--** Website for the Office of the National Coordinator for Health Information Technology's Regional Extension Service Centers, which were established to provide Technical Assistance and support toward implementation of the ACA

http://healthreform.kff.org/Exchanges -- Website of the Kaiser Family Foundation dedicated to assisting with understanding the Exchanges

www.hitrc-collaborative.org—repository of information and tools related to management of ACA implementation

www.nashp.org --- Website of the National Association of State Health Policy

http://www.nasi.org/research/2011/designing-exchange-toolkit-state-policymakers?gclid=CJnZ89HrnKsCFchgTAod-GbplA **–** Webssite of the National Academy of Social Insurance, which provides policymakers with tips on designing an Exchange

www.NESCSO.org—New England States Consortium Systems Organization—six New England states plus University of Massachusetts

www.niem.gov—web site of the National Information Exchange Model

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