Guidehouse
Outwit Complexity

Proposal for:

Reduced Reliance on Congregate Care

RFP 115714 O3

Presented to:

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

State of Nebraska
Department of Health and Human Services
301 Centennial Mall South
Lincoln, Nebraska 68509

TECHNICAL PROPOSAL

June 14, 2023

Presented by:

Tamyra Porter
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tporter@guidhouse.com

guidehouse.com

This proposal does not constitute a contract to perform services. Any contract arising out of this proposal will be subject to the execution of a mutually acceptable formal engagement contract.

Guidehouse

June 14, 2023

Dana Crawford-Smith
State of Nebraska
Department of Health and Human Services
301 Centennial Mall S
Lincoln, Nebraska 68508

Via electronic submission

RE: RFP 115714 O3–Reduced Reliance on Congregate Care | Guidehouse Response

Dear Ms. Crawford-Smith:

Guidehouse Inc. ("Guidehouse" or “we/us/our”) appreciates the opportunity to provide the State of Nebraska Department of Health and Human Services ("DHHS”, "Company" or "you/your") with this Reduced Reliance on Congregate Care Services proposal (the “Proposal”). Our vast and unparalleled professional and personal experience working with the Intellectual/Developmental Disabilities (“I/DD”) population uniquely positions us to work in partnership with DHHS to achieve its goal of reducing reliance on congregate care in the Comprehensive Developmental Disabilities (“CDD”) Waiver. We look forward to the opportunity to navigate the opportunities this engagement brings so we may assist DHHS in furthering its goal to move persons to the least restrictive environment.

Our Home- and Community-Based Services (“HCBS”) team has worked with more than 30 states across the United States to assess, design, and implement program upgrades to garner efficiency and improve participant satisfaction with services. Our experience and in-depth knowledge of other states’ HCBS programs provide a detailed look at innovative approaches and how other states have approached nationwide challenges from policy development to implementation and monitoring.

Many Guidehouse employees have personal and professional experience with individuals with I/DD. As family and friends to individuals with I/DD, we are passionate about the opportunities and supports offered and have a personal and professional mission to improve the quality of life for these individuals.

This Proposal will be used by the parties to finalize the business terms and is intended for informational purposes only. Upon finalizing the business terms, Guidehouse will prepare a definitive engagement agreement for your review and execution. This Proposal does not constitute a contract to perform services and neither party has committed to any of the terms described herein.

We would be pleased to review and discuss this Proposal with you in more detail and revise the scope, work plan, and business arrangements to best meet your needs and expectations. Please contact Tamyra Porter at 202.973.3138 or tporter@guidehouse.com with questions, for additional information, and / or discussion of next steps.

Sincerely,

Tamyra Porter
Partner

Table of Contents

Section 1 VI.A.1. Corporate Overview

1.A. Identification and Information

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Corporate Name: Guidehouse Inc.

Address: Global Headquarters – Tyson Corner
1676 International Drive, Suite 800
McLean, Virginia 22102

Corporate Organization: 'C' Corporation

State of Incorporation: Delaware

Year of Organization: 1996

Name and Form of Organization Changes Since First Organized: Guidehouse, is formed from the legacy firms of PricewaterhouseCoopers ("PWC") and Navigant Consulting Inc. While as one firm we are five years in the making, our 27 years of business positions us as a leading global provider of consulting services to the public and commercial markets with broad capabilities in management, technology, and risk consulting. We help clients address their toughest challenges and navigate significant regulatory pressures with a focus on transformational change, business resiliency, and technology-driven innovation. Across a range of advisory, consulting, outsourcing, and digital services, we create scalable, innovative solutions that prepare our clients for future growth and success. Guidehouse Inc. is owned by Guidehouse LLP, a Delaware limited liability partnership.

In the past two years, Guidehouse has completed acquisitions of Dovel Technologies and Grant Thornton's Public Sector Advisory practice, bringing additional cutting-edge technologies in advanced data analytics and artificial intelligence, enterprise digital modernization and system integration, and cloud adoption and infrastructure optimization offerings to complement Guidehouse's service offerings.

Guidehouse is a Veritas Capital portfolio company, led by seasoned professionals with proven and diverse expertise in traditional and emerging technologies, markets, and agenda-setting issues driving national and global economies. Veritas Capital is a premier technology firm with in-depth knowledge and understanding that focuses on the intersection of technology and government. As a Veritas Capital portfolio company, Guidehouse is dedicated to identifying and executing strategic levers that will drive transformational growth and impact changes in organizations.

Headquartered near Washington, DC, the company has more than 16,500 professionals in more than 50 locations globally. For more information on locations, please visit https://guidehouse.com/locations .

Guidehouse is a leading global provider of consulting services to the public sector and commercial markets, with broad capabilities in management, technology, and risk consulting. By combining our public and private sector expertise, we help clients address their most complex challenges and navigate significant regulatory pressures focusing on transformational change, business resiliency, and technology-driven innovation. Across a range of advisory, consulting, outsourcing, and digital services, we create scalable, innovative solutions that help our clients outwit complexity and position them for future growth and success.

Guidehouse Health Team

Guidehouse is the only global consultancy that integrates strategy and policy expertise with deep industry partnerships across the health ecosystem – and beyond.

With 16 KLAS #1 rankings, the Guidehouse Health team helps hospitals and health systems, federal and state government agencies, life sciences and retail companies, and payers solve their most complex issues, overcome unique market challenges, and deliver innovative services to their communities and customers.

The Guidehouse Health team includes public sector and provider administrators, clinicians, scientists, and other experts with decades of strategy, funding, policy, revenue cycle, digital and retail health, managed care, and managed services experience.

Our clients include more than 300 health systems and 38 of the 50 top pharmaceutical companies. We serve federal agencies on the forefront of national healthcare issues to help them improve both the quality and value of the healthcare purchased for, and provided by, the federal government. Our state clients include Medicaid, mental health, developmental disabilities, public health, education, and social services agencies, as well as workers compensation and state employee groups on issues such as service delivery, financing, and operations.

Our primary solutions are in these areas:

- **Strategy and Innovation:** Guidehouse works with organizations to provide solutions for developing a market-leading strategy for long-term top performance, growth, and sustainability.
- **Revenue Cycle and Financial Solutions:** Guidehouse supports revenue cycle clarity and results through technology optimization, performance improvement, and business process outsourcing.
- **Operational Effectiveness:** Our consultants help healthcare providers achieve and sustain robust clinical, healthcare workforce management, operational, and financial results.
- **Clinical Transformation:** Composed of clinicians, administrators, public health leaders, and health plan executives with decades of experience, Guidehouse's clinical transformation team delivers aligned solutions designed to achieve excellence in patient and organizational outcomes.
- **Digital / Health IT:** Guidehouse experts provide comprehensive technology solutions in such areas as cybersecurity, EHR interoperability and optimization, data analytics, enterprise resource planning, digital transformation, IT strategy and effectiveness, process automation, and much more.
- **Managed Services:** Guidehouse's revenue cycle managed services practice, including its innovative processes and technology, is recognized as one of the best in the industry,

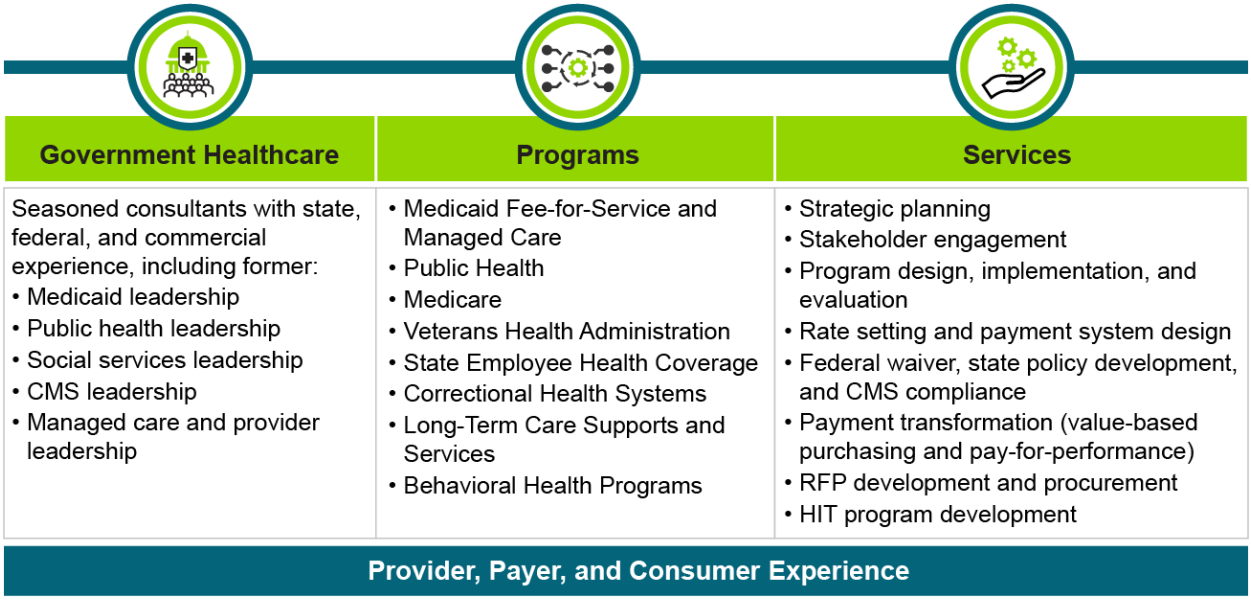
having earned multiple Best in KLAS Awards. The firm also has experience in successfully developing and leading health system revenue cycle organizations.

Public Health Experience

Guidehouse is a leading global provider of consulting services to governmental groups and agencies, with broad capabilities in management, technology, and risk consulting. Our Government Team focuses on the challenges state government agencies and federal agencies face in administering and overseeing publicly financed healthcare systems. Our teams are positioned to address both state and federal challenges and to provide tailored, practical solutions to bridge the gap between these two critical players.

The figure below shows examples of our team members, programs, and services. Our clients benefit from a diverse set of perspectives; our staff includes former public health leadership, Medicaid leadership, social services agency leadership, Centers for Medicare and Medicaid Services ("CMS") leadership, and managed care and provider leadership.

Figure 1. Examples of Guidehouse's Experience and Services



1.B. Financial Statements

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

Guidehouse has provided its audited financial statements and banking reference as a separate file named *RFP115714 O3_PROPRIETARY INFORMATION_Guidehouse_6_14_23* as instructed in the Scope of Services section of the RFP.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

We are a party to a variety of legal proceedings that arise in the normal course of our business. While the results of these legal proceedings cannot be predicted with certainty, we believe that the final outcome of these proceedings will not have a material adverse effect, individually or in the aggregate, on our results of operations or financial condition. To the best of our knowledge, Guidehouse does not have any pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of our organization.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Guidehouse understands this requirement.

1.C. Change of Ownership

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

At the time of this proposal submission, we do not anticipate any change of ownership or control of the company during the twelve months following the proposal due date. If the proposal team is made aware of any possible changes to company ownership or control, we acknowledge and understand that notification to the State is required.

1.D. Office Location

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

Guidehouse will manage this solicitation for the State of Nebraska DHHS from our Healthcare practice located at 150 North Riverside Plaza, Suite 2100, Chicago, Illinois. We will have no challenge in meeting staffing requirements, given our healthcare team has more than 600 professionals from whom we can draw additional resources.

In addition to the locations identified above, Guidehouse has offices throughout the United States and around the world providing a deep bench of expert consultants to support our work under this solicitation. With our team of consultants reaching beyond the borders of individual states, our staff often work remotely. Guidehouse provides a number of electronic platforms to communicate frequently with its clients and manage and track project information. We would utilize these same innovative tools with the State of Nebraska and its other stakeholders as necessary under this engagement. When the State elects to work onsite, our team can be onsite as needed or requested, to provide in-person support, acknowledging the value-add, and relationship building that in-person interaction fosters. Guidehouse further appreciates the limited capacity of many State resources that are stretched thin due to COVID-19 and the strain of this pandemic. When the State elects to hold its meetings remotely, Guidehouse will leverage secure video conferencing platforms (or support the use of the State's web-conferencing capabilities) to protect sensitive and potentially confidential information.

1.E. Relationships with The State

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Contracting Agency	Contract Details
State of Nebraska	**Contract Number:** Contract #90758 O4 **Term:** 6/25/2020 – 6/24/2022 **Summary of Services:** Public Assistance, Individual Assistance, and Hazard Mitigation Assistance.
Nebraska Department of Health and Human Services	**Contract Number:** NE Contract #58871 O4 **Term:** 12/20/2013–6/30/2020 **Summary of Services:** Determined DSH Payments and Calculated UPL Demonstrations.

January 2020

Led the design of new prospective payment methods for the Nebraska Association of Medicaid Health Plans in collaboration with Nebraska Medicaid.

The new OPPS implemented in January 2020 is based on EAPGs for the reimbursement of outpatient services by managed care plans instead of their prior cost-based rates. The Guidehouse team helped to develop a budget neutral outpatient EAPG reimbursement system with multiple peer groups and supported the managed care plans with communicating rates to stakeholders including the Nebraska Medicaid program and hospital industry stakeholders. The team conducted the following action steps:

- Coordinated discussions with the managed care plans and Nebraska Medicaid regarding desired outcomes of the outpatient EAPG payment method
- Suggested and helped evaluate EAPG reimbursement policy decisions
- Modeled rates to demonstrate the fiscal impact to peer groups and individual hospitals
- Summarized results of new pricing models for the managed care plans and presented results to hospital industry stakeholders and Nebraska Medicaid
- Provided training presentations to the managed care plans and hospitals with additional training in 2021

1.F. Employee Relations to State

If any Party named in the bidder's proposal response is or was an employee of the State within the past twenty-four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

No, not applicable. To the best of our knowledge, no Party named in the contractor's proposal response is or was an employee of the State within the past twenty-four (24) months.

1.G. Contract Performance

If the bidder or any proposed subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

No, to the best of our knowledge Guidehouse has not had a contract terminated for default during the past five (5) years.

Guidehouse is a large privately held company that provides consulting services to a broad range of public, private, and governmental entities. Each business day, Guidehouse enters into hundreds of contracts in a wide variety of matters and for a wide range of clients, both governmental and commercial. Guidehouse does not have a central database containing this type of information about these contracts. Furthermore, Guidehouse is subject to the confidentiality and non-disclosure terms in all of its client contracts and therefore cannot disclose any information identifying the client or the service performed under the contract to third parties. Given the large volume of work, contracts are undoubtedly terminated or not renewed from time to time for a wide variety of reasons, the vast majority of which have only to do with normal business reasons or necessities.

1.H. Summary of Corporate Experience

The bidder should provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

Guidehouse has provided three projects which demonstrate our experience performing work similar in size, scope, and complexity of this proposal.

Oklahoma Health Care Authority

Guidehouse conducted an independent assessment of Oklahoma's six 1915(c) waivers through a contract with the Oklahoma Health Care Authority ("OHCA") Long Term Services and Supports ("LTSS"). Throughout the year-long engagement, Guidehouse collected and analyzed data (i.e., Medicaid enrollment, provider networks, critical incidents), engaged caregivers, providers, and State staff to understand current and future state of waiver services, and convened additional states and leading disability organizations to develop a best practice toolkit. Through extensive stakeholder engagement efforts and operational analysis, Guidehouse developed a Final Report with nine recommendations for the State to pursue that:

- Standardized practices and procedures across waivers
- Introduced efficiencies for both State workforce and HCBS providers
- Identified ways to improve and modernize practices to adhere to evolving federal (i.e., CMS expectations)

- Maximized the use of data, technology, and subject matter expertise

Based on our extensive research, data analysis, and stakeholder engagement with Oklahoma, we believe we have the necessary expertise to deliver quality results through this engagement with Nebraska.

OKLAHOMA Health Care Authority	Home- and Community-Based Services Operational Assessment
Time Period of Project	February 2022 – March 2023
Scheduled Date & Budget Actual Completion Date & Budget	Scheduled Date and Budget: February 2022 – February 2023; $535,500 Actual Completion Date and Budget: February 2022 – March 2023; $535,500
Bidders Responsibilities	• Evaluated key operational workflows within the State's home and community-based programs, such as critical incident management, self-directed services, case management systems, and provider network, and provided recommendations for improvement • Conducted an environmental scan of long-term care in the State including 1915(c) waivers serving individuals with developmental disabilities, aging population, and medically fragile population • Conducted stakeholder engagement with program members and providers, State staff across agencies, national experts, and staff members of other states in interview and focus group formats • Conducted qualitative data analysis of interviews and focus group comments to identify common themes • Developed recommendations to streamline internal processes, improved efficiencies, and leverage technology in the State's HCBS waiver system
Reference Information	**David Ward, Director** Long Term Services and Supports **Address:** 4345 N. Lincoln Blvd, Oklahoma City, Oklahoma 73105 **Phone:** (405) 522-7776 **Email:** david.ward@okhca.org
Worked Performed as	Prime Contractor
Project Description	

Background

Guidehouse conducted a collaborative exploratory operational assessment of the State's HCBS waivers to assess current and desired future state of HCBS operations. Overall, the assessment identified mechanisms to:

- Standardize practices across waivers
- Introduce efficiencies for both state workforce and HCBS providers
- Improve / modernize practices that may not fully adhere to evolving federal expectations for states
- Maximize the use of data, technology, and subject matter expertise

OKLAHOMA Health Care Authority

Home- and Community-Based Services Operational Assessment

The State's HCBS waivers provide services and support to nearly 30,000 individuals with disabilities and aging adults. 2022 legislation for waitlist elimination efforts and new agency leadership heightened the need for the operational assessment to promote efficiencies across waiver operations.

Over the course of a year, our team collaborated with the two operating agencies, OHCA and Oklahoma Department of Human Services (OHS), to understand cross-agency collaboration, current and future state of waiver operations, and identify mechanisms to further advance HCBS waiver programs.

Approach

Key activities included:

- Collected and analyzed baseline program performance data to identify opportunities that drive program improvement and address compliance risks
- Facilitated 20 internal interviews with cross-agency leadership to identify current state, challenges, and areas of opportunity to improve efficiency and better serve waiver participants and providers
- Performed cross-agency workflow analysis in nine operational areas using a people, processes, and technology framework
- Conducted 10 virtual workflow analysis discussions with state staff
- Facilitated extensive, statewide, external stakeholder engagement via in-person and virtual focus groups with caregivers and providers to include:
    - Ten in-person focus groups in five areas of the state
    - Three virtual focus groups
    - Two advisory council interviews
- Collected best practice and national expertise through 15 interviews with seven peer states and five national disability and aging organizations
- Identified opportunities to enhance coordination, standardization, and data management across waivers

Results

Key results included:

- Engaged 135 individuals with a vested interest in HCBS consisting of caregivers, providers, and state staff
- Developed and delivered a Final Report consisting of nine recommendations to OHCA and OHS leadership
- Created a legislative one-pager of Guidehouse's nine recommendations
- Developed a best practice toolkit consisting of research and subject matter expertise from peer states and national organizations
- Provided ongoing cross-agency collaboration support to OHCA LTSS and OHS leadership through involvement in a Leadership Summit after release of the Final Report

Kentucky Department of Medicaid Services

Guidehouse assisted the Commonwealth of Kentucky Department of Medicaid Services ("DMS") to evaluate the six 1915(c) waivers in the State and perform an operational and waiver redesign assessment. Additionally, Guidehouse conducted a comprehensive study of HCBS payment methodologies and rates to make payment methodologies and rates more consistent across waivers and apply value-based and tiered payment methods. The Commonwealth's waivers provide services to individuals of all ages, including the aging population, with physical, mental, and developmental disabilities as well as individuals with acquired brain injuries. Guidehouse conducted internal and administrative assessments, Kentucky 1915(c) waiver assessments, stakeholder engagement practices, as well as developed, and administered cost and wage surveys and developed rate components, rate recommendations, and related fiscal impacts. Guidehouse met the project's goals by identifying ways to optimize the Kentucky 1915(c) waiver programs, including program oversight and administration, quality of care, and service delivery to improve provider and participant experience. These activities correlate well with the experience needed to address Tasks 2-5 in the Nebraska Scope of Work.

TEAM KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES	State & Operational 1915(c) Waivers Redesign Assessment
Time Period of Project	April 2017-June 2020
Scheduled Date & Budget Actual Completion Date & Budget	$8 Million Total Contract Value (inception through contract term)
Bidders Responsibilities	Conducted 1915(c) waiver evaluation and operational and waiver redesign assessment
Reference Information	**Pam Smith, Director** Division of Community Alternatives **Address:** 275 E. Main St. 6W-A, Frankfort, Kentucky 40621 **Phone:** (502) 564-4321, ext 2105 **Email:** pam.smith@ky.gov
Worked Performed as	Prime Contractor
Project Description	

To provide recommendations in these areas, Guidehouse reviewed both the current state operations of Kentucky's 1915(c) waiver programs and the structure and contents of Kentucky's six 1915(c) waivers. To complete this support Guidehouse:

- Reviewed the operational processes and the current 1915(c) waivers within the Cabinet for Health and Family Services for administering the waivers to identify areas for refinement
- Reviewed the current 1915(c) waivers in Kentucky and assessed program design and waiver content
- Facilitated focus groups consisting of diverse populations from different communities across the State and reviewed all public comments sent to the DMS public comment inbox

As a result of this multi-pronged assessment, Guidehouse developed recommendations for a first phase of HCBS program improvement:

- HCBS payment methodology, including a provider rate study, methods to make payment methodologies and rates more consistent across waivers and apply value-based and tiered payment methods
- Development of more standardized and streamlined approaches to defining waiver services, managing waivers, and executing agency operational workflows
- Care planning and budgeting, including transition to universal assessment tool and assessment process, and needs-based individual budgeting, and participant directed services
- Case management, including terms of case manager and support broker contracts, scope of case manager duties and accountabilities, case management tools and training, and oversight
- Stakeholder outreach and engagement

Final project results included:

- The Department proceeded with post-assessment recommendations to improve program operations and integrity
- All formal federal and state regulations have been totally redesigned for cross-program consistency, best practice integration, and ease of use
- The State now has data-informed payment rates that are consistent for like services across programs and objectively documented, and will comply with CMS requirements for payment methodology going forward
- Due to the policy and procedural changes made as a result of this process, 1915(c) participants in Kentucky now have more ownership over the manner in which their services are delivered, embrace independence, experience improvements in resources to make informed decisions and choices about services

New York Office of People with Developmental Disabilities

Guidehouse is currently working in conjunction with New York's Office for People With Developmental Disabilities ("OPWDD") to prepare a Final Report and recommendations on service delivery models, including managed care, and program requirements that yield progress toward the goals outlined in OPWDD's 2023-2027 Strategic Plan. To best provide these recommendations, we have engaged in the following activities:

- Initial Report – Prepared Initial Legislative Report December 2022
- Best Practice and National Trends – Identified best practice peer states and national experts to establish managed care best practices for the I/DD population
- Environmental Scan, Literature Review, and Data Analysis – Collected and analyze publicly available and state-provided data to establish Managed Care Assessment baseline
- Stakeholder Engagement (OPWDD Internal) – Identified and engaged internal OPWDD leadership and New York State ("NYS") sister agencies to understand current state and opportunities that support the managed care assessment for the I/DD population

- Stakeholder Engagement (OPWDD External) – Collecting and analyzing external stakeholder input that considers the real-world New York-specific implications of policy implementation

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities	Managed Care Assessment
Time Period of Project	November 2022 – Present
Scheduled Date & Budget Actual Completion Date & Budget	Scheduled Completion Date – March 2024 Budget – $1,444,000 Actual Completion Date – NA (ongoing) Actual Budget – NA (ongoing)
Bidders Responsibilities	Perform an environmental scan and make recommendations for service delivery models for New York's I/DD population
Reference Information	**James Kaufman, Deputy Director** Division of Policy and Program Development **Address:** 44 Holland Ave, Albany, NY 12229 **Phone:** (518) 486-6466 **Email:** James.Kaufman@opwdd.ny.gov
Worked Performed as	Prime Contractor
Project Description	

Background

In recent years, NYS has implemented several Medicaid Managed Care programs including Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities and Mainstream Managed Care, however, key populations, such as the I/DD population, remain in the fee-for-service delivery system. NY OPWDD oversees programs for the I/DD population and has contracted with Guidehouse to conduct a study to evaluate how the implementation of managed care would assist OPWDD in improving LTSS for people with I/DD in NYS.

Approach

The Guidehouse team is working closely with NY OPWDD, to deliver a final report that outlines recommendations on whether managed care would assist OPWDD in improving LTSS for people with I/DD and if not, what service delivery is a best fit for the I/DD population. Guidehouse will submit the following public reports:

1. **Initial Report:** Report was submitted to OPWDD in December 2022 and included:
   a. Summary of OPWDD goals and objectives
   b. Overview of current delivery system in New York including how managed care is used today
   c. Environmental scan and high-level overview of service delivery models, next steps, and timing of Final Report

   Link: https://opwdd.ny.gov/system/files/documents/2023/01/nys-opwdd-managed-care-assessment.pdf
2. **Final Report:** To be submitted to OPWDD in February 2024 and will include:
   a. **Service Delivery Model Study Methodology and Findings:** Comprehensive summary of the service delivery study methodology and findings focusing on managed care and other options currently implemented nationally.

b. **OPWDD Program Goals:** Detailed perspective of OPWDD program goals, objectives, and measures of success to execute and monitor OPWDD's progress towards achieving goals based on the recommended service delivery system.

c. **Final Recommendations:** Recommended next steps for selection and implementation of a service delivery model. This will include key program requirements of the recommended service delivery model to successfully serve the I/DD population across New York.

To complete these two public reports Guidehouse is conducting the following:

1. **Stakeholder Engagement:**
   a. Conducting interviews with key stakeholders internal to NY OPWDD and key external stakeholder groups (e.g., provider associations, individuals with I/DD and their families, advocacy groups, and advisory boards).
   b. Developing and disseminating field surveys to individuals with I/DD and providers
2. **Environmental Scan, Literature review, and Data Analysis:**
   a. Conducting a review of available data and policies to gain a comprehensive understanding of current state of I/DD programs in NYS.
3. **Identifying Best Practice and National trends from other states:**
   a. Conducting interviews with the following Peer States: California, Florida, Illinois, Kansas, Massachusetts, Michigan, North Carolina, Ohio, Pennsylvania, and Tennessee.
   b. Conducting interviews with National Experts from the following: ANCOR, TennCare, and National Association of State Directors of Developmental Disabilities Services (NASDDDS).

Results

Project still in progress. Final Report will be submitted in February 2024.

ii. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal.

Please see above narrative descriptions highlighting similar work Guidehouse performed for the states of Oklahoma, Kentucky, and New York. Similar to DHHS' goal as set forth in this RFP, an overarching theme was to facilitate HCBS waiver programs and make them more efficient so that persons can live in the least restrictive settings. Further, the scope of work for each encompassed the same scope of work as set forth in *Section V.D*. of the RFP. Namely, in addition to working with waiver programs that targeted persons with I/DD, for each of the above engagements, Guidehouse was charged with:

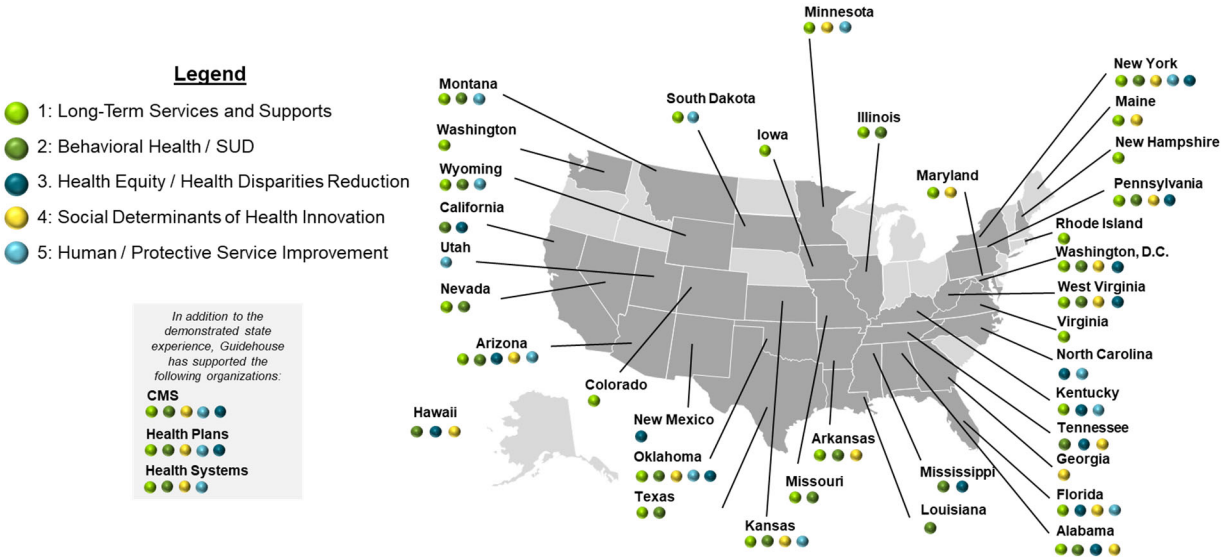
a. Assessing the overall HCBS environment
b. Conducting an environmental assessment on the current landscape
c. Gathering, planning, and examining current data
d. Identifying and examining existing data sources
e. Develop and assist with strategies to implement incentives for agency providers to find independent living or least restrictive living environments

Our mission at Guidehouse is to solve complex problems, build trust in society, and empower our clients to shape the future. As we work side-by-side with our clients to solve these problems, we confirm our mission's importance and bring it to life for future generations.

Our humanistic approach considers the real-world impacts of our work on society, government, community, and family levels. Our goal, aligning with DHHS, is to solve big problems. We understand big or small solutions can have a tremendous impact and will work to address complexities and cultivate a team culture with DHHS that is supportive and sets up an environment conducive to success. Our approach demonstrates these values, especially in I/DD, long-term care, and HCBS, which operate in a community and person-centric environment. Our consultants strive to meet engagement expectations while building long-lasting relationships that go beyond the boundaries of a given project.

Guidehouse brings proven experience that will allow us to support DHHS with assessing the independent and residential care living environments to determine the best strategies for the state to promote independence through a less restrictive living environment. Guidehouse will complete a thorough assessment to develop successful and sustainable strategies by assessing the impacts of independent living or least restrictive living based on structure, process, technology, and people impacts. Guidehouse will prepare and submit recommendations based on its assessment and the data it develops that will guide Nebraska DHHS to reduce reliance on congregate care.

Figure 2. Guidehouse Medicaid / Health and Human Services Solutions Map



iii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.

Guidehouse served as the primary contractor on each of these engagements except for New York. During this engagement, we collaborated with ADvancing States, MBO Consulting, and Blount Consulting. These subcontractors provided expanded knowledge of National managed long-term service and supports (“MLTSS”) and the New York managed care environment.

iv. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

Guidehouse served as the primary contractor on each of these engagements.

1.I. Summary of Proposed Personnel / Management Approach

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

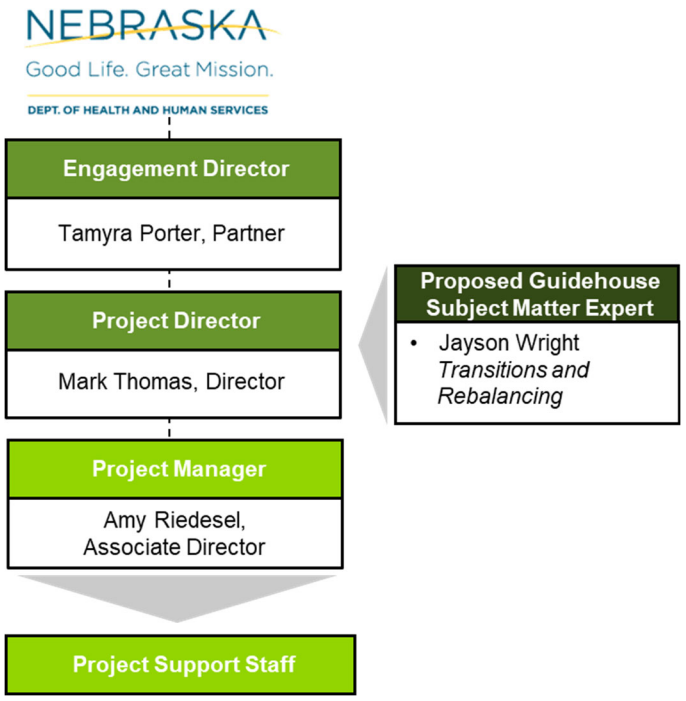
The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Management Approach

Guidehouse's committed resources are healthcare professionals with numerous years of hands-on managerial and subject matter experience. We are confident the State will find our collective complement of resources second to none. As a result, the State can be confident that the identified opportunities we co-develop will be very pragmatic, and that Guidehouse will work closely with the State for the accuracy, reasonableness, and sustainability of the solutions generated. We have identified the management team for a representative project below that will lead our team of healthcare professionals and call upon subject matter experts and support staff to complete assigned tasks.

Project Team



Below we have included a detailed description of our proposed project team for this engagement. Our team leaders Tamyra Porter, Mark Thomas, and Amy Riedesel have all previously worked on projects with I/DD populations across numerous states.

- **Engagement Director:** Tamyra Porter is the Partner overseeing the State of Nebraska account. She has ultimate oversight of the engagement and responsibility of maintaining client satisfaction. Tamyra is a main contact for Nebraska particularly with regard to contracting issues, quality oversight and management, and risk mitigation.
- **Project Director.** Mark Thomas, the Project Director, will be responsible for the overall direction of the project, the quality of all deliverables, the project budget, and the project's timely completion. He will serve as the primary contact for contracting purposes and will oversee the implementation and completion of all project tasks and deliverables. Mark provides guidance to the Project Manager and partners and will regularly review project work and assess client satisfaction. He will also confirm that resources are dedicated as required for successful delivery of project deliverables within the required timeline.
- **Project Manager.** Amy Riedesel, the Project Manager, will coordinate the work and schedule of our internal team to implement the project work plan. She will be responsible for team management and the timely completion of deliverables. Amy will be one of Nebraska's primary points of contact and will coordinate and lead status and planning meetings to establish priorities and obtain team consensus on issues. The Project Lead will coordinate the day-to-day project activities and maintain overall responsibility for the project schedule and budget.
- **Subject Matter Experts.** Guidehouse often assigns relevant Subject Matter Experts to supplement our proposed project teams, as needed. These individuals have extensive experience in areas relevant to the proposed scope of work. The project team can draw from this group as appropriate to address Nebraska's analysis, planning, and implementation needs under this contract. For this engagement, we will use Jayson Wright.
- **Project Support Staff.** Our Project Support consists of individuals who will perform the tasks specified in the scope of work and under the direction of the Project Director and Project Lead. Our proposed Project Support members' responsibilities will generally include:
    - Conducting project research and analysis and perform project work activities (individual activities and responsibilities will be assigned based on expertise required and other task specifics)
    - Developing reports and presentation materials
    - Providing quality control on all deliverables
    - Assisting with development of all deliverables and project status reporting for project activities
    - Working closely with project leadership to resolve issues and obtain policy decisions as appropriate to keep the project on schedule and on budget

Guidehouse provides DHHS with a collaborator that possesses organizational and team-based skills, capabilities, and techniques including:

- **Expert staff with firsthand experience** – Guidehouse's proposed project/support team includes persons with direct experience working with and directly for other state I/DD waiver programs. They also include a deep bench of national experts that understand national best practices and program evaluation and implementation. Our staff has robust experience assisting state agencies with data-driven recommendations to enhance and improve existing programs like the CDD Waiver.
- **Access to data capabilities and proprietary data sets** – Guidehouse's (in)Sight Health™ data capabilities offer DHHS access to a comprehensive library of public and purchased data sets. Additional information on Guidehouse's (in)Sight Health capabilities can be found in *Section V.C.1.* of this RFP response.
- **Meet project management expectations and deliverable timelines** – Guidehouse has vast experience in being able to quickly ramp up engagement needs in order to assess current health and human services environments and deliver timely reports and recommendations. Our experienced team brings deep expertise in program evaluation and TruePMO℠ methodology, 1915(c) waivers, and the I/DD population to quickly develop meaningful deliverables in a short time.
- **Leverage tested and flexible study methodologies that yield success while adaptable to an ever-changing environment** – As COVID-19 has changed several gathering and outreach norms, especially among many stakeholders who may be considered at high risk and combined with limited broadband access in many rural areas, our approach to evaluation studies delivers effective stakeholder engagement while remaining flexible to the needs of stakeholders. These methodologies also allow us to more effectively gather diverse and often under-represented perspectives which results in more comprehensive and inclusive project results.
- **Foster a collaborative environment** – We will leverage DHHS CDD Waiver knowledge while keeping Guidehouse evaluation methodologies and recommendation objectives. Guidehouse will maintain an ongoing, collaborative, and active relationship with DHHS throughout the project lifecycle. To promote objectivity, we will focus on inclusive feedback from all constituents / stakeholders.

Name and Role	Relevant Experience
Tamyra Porter *Partner* Engagement Director	Tamyra leads our State Government sub-practice and brings over 20 years of government sector project and engagement management in a variety of states. Tamyra supports clients in the full life-cycle of program design including waiver support, stakeholder engagement, procurement, and contract development as well as robust development of organizational redesign supported by training and resource development for program oversight, monitoring, and quality improvement. Tamyra has deep expertise in special populations, long-term care, social determinants of health, and managed care. She has also led and advised sizable HCBS-related engagements for agencies in a diverse array of states including, Alabama, Arkansas, New Hampshire, Oklahoma, Rhode Island, South Dakota, etc.

Name and Role	Relevant Experience
Mark Thomas *Director* Project Director	Mark is an accomplished C-Suite healthcare executive with demonstrated local, state, and national organizational and operational leadership experience in private non-profit and public sector service delivery, management, and oversight. LTSS / Medicaid subject matter expert in the following areas Medicaid HCBS Waitlist Elimination / Reduction, Public Institution Downsizing / Rebalancing,

Name and Role	Relevant Experience
	Waiver Resource Allocation, Tiered Waiver Development / Implementation, Department of Justice Settlement Agreement for I/DD, and Behavioral Health, HBCS settings Compliance, CMS relations, COVID-19 response for public and vulnerable populations. Mark has performed operational and programmatic oversight of the statewide Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, Office of Behavioral Health, Office of Public Health, Five State Operated Facilities, and Statewide Human Service Interagency Council (Regional Operations). He served as the Governor Appointee for nine years under Republican and Democratic Governors and served as Board President of the National Association of State Developmental Disability Directors (NASDDDS).

Name and Role	Relevant Experience
Amy R. Riedesel, MPA *Associate Director* Project Manager Subject Matter Expert	As a consummate leader in the work of LTSS across populations, Amy has more than 18 years' experience building and leading successful community-based programs. Her work is founded in person-centered philosophy and true community inclusion for people with intellectual or developmental disabilities and aging and disability populations. She has been a state level leader of transformational change of health and social programs. She has led state transformation of self-direction models for I/DD, and competitive integrated employment through support employment services leading to State of Georgia becoming an Employment First State in 2018.Amy has a keen ability to lead change through collaboration across partners. She can take complex issues and break them down in digestible ways to build efforts to work toward a common goal across internal and external partners, advocates, and stakeholders. She is committed to work to improve systems to recognize, respond to and meet individual needs, and engage partners to find common ground to make it happen.

Name and Role	Relevant Experience
Jayson Wright *Managing Consultant* Subject Matter Expert	Jayson (Jay) has nearly 15 years of experience working with state Health and Human Services agencies supporting Long-term Services and Supports (LTSS) through a wide variety of projects and programs. His is passionate about improving the lives of the aging and disability populations by enhancing the services and support systems that allow these individuals to lead independent lives. Jay specializes in creating programs and systems to address new challenges or take advantage of new opportunities. He has supported the development and implementation of nursing home transition programs, Community Health Hubs that bridge clinical and home and community-based services (HCBS), and as of 2023 supported the design of Multisector Plans on Aging.

Complete biographies of the proposed team are located in Appendix A below.

1.J. Subcontractors

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

v. name, address, and telephone number of the subcontractor(s),

vi specific tasks for each subcontractor(s),

vii. percentage of performance hours intended for each subcontract; and

viii. total percentage of subcontractor(s) performance hours.

Guidehouse possesses the ability to solely fulfil the obligations under this RFP and therefore, we are not proposing the use of Subcontractors in our response.

Section 2 VI.2. Technical Approach

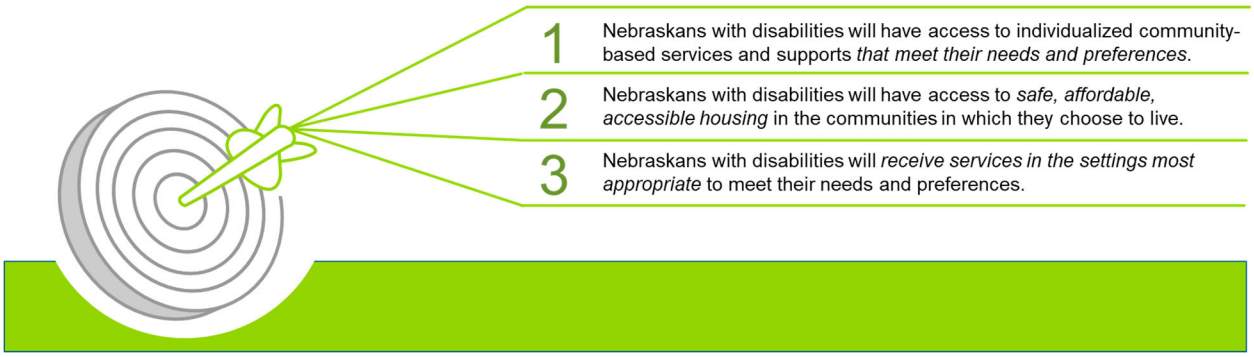
2.A. Understanding of the Project Environment

The Developmental Disabilities Division serves one of the most rewarding populations but also the population with the most complex service and support needs across the care continuum. Individuals and their families require highly individualized supports that match wants, needs, and preferences. One of the most important preferences that must be taken into account is the setting in which the individual lives.

We understand the post-COVID public health emergency ("PHE") environment for Medicaid-funded HCBS will be as complex as the first few months of the PHE itself. We support our clients through this complexity every day and believe that now is the opportune time to take a step back and evaluate our systems. The PHE was a stress test for HCBS and identified the strengths of our systems, as well as opportunities for change.

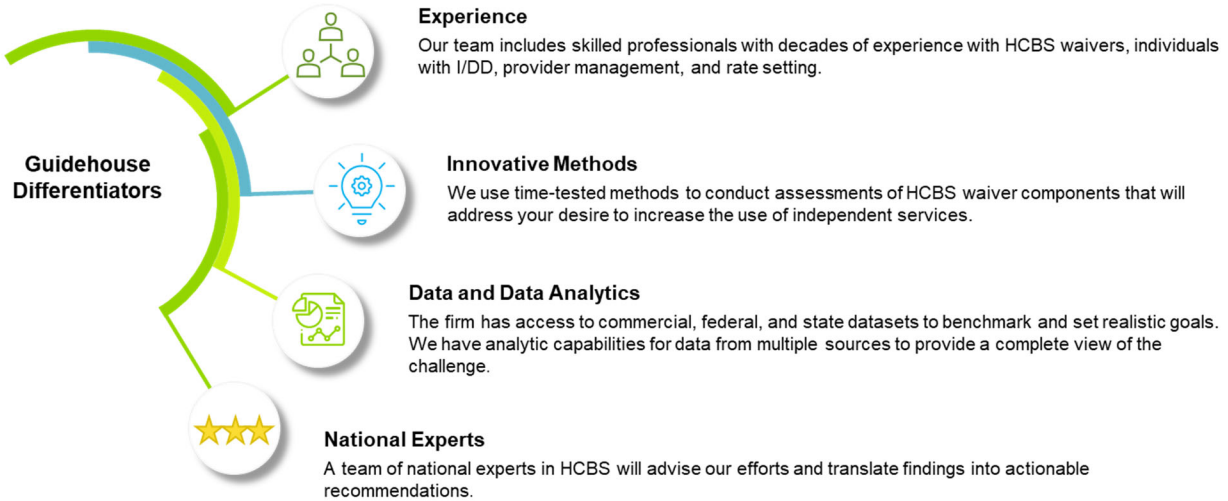
Despite post-COVID activities, Guidehouse is also aware of the additional changes in the Nebraska health and human services landscape. Over the next year, the Department seeks to implement significant changes to the provider landscape that address the needs of individuals with I/DD:

- **PHE Unwinding:** All state Medicaid programs are required to unwind PHE-era flexibilities as required by the Family First Coronavirus Response Act. Meanwhile, HCBS programs must maintain American Rescue Plan Act ("ARPA") Section 9817-related flexibilities until March 31, 2025 (or until associated funds are expended).
- **ARPA Section 9817 HCBS Spending Plan Initiatives:** States that submitted ARPA HCBS Spending Plans have multiple, high-impact initiatives planned or in-progress to support expansion and enhancement of HCBS services. Guidehouse notes that the initiative to reduce reliance on congregate care was set forth in Nebraska's ARPA Section 9817 Spending Plan in its efforts to expand and enhance HCBS services.
- Nebraska Governor's approval of stabilization payments to developmental disability service providers: The governor announced one-time stabilization payments to I/DD service providers in May of 2023.
- **LB 376 I/DD Waiver Evaluation as overseen by the Governor's Developmental Disability Advisory Council:** The Division of Developmental Disabilities ("DDD") is currently conducting an evaluation of all HCBS waivers that address the needs of individuals with I/DD as well as implementing an additional Family Support suite of services.
- The initiative to reduce reliance on congregate care as described in this RFP.
- Additionally, we understand each initiative the Department undertakes must address the goals outlined in the Nebraska *Olmstead* Plan. The plan puts forth seven goals for the service environment that supports individuals with disabilities. The initiatives outlined in this RFP can impact three of those goals:



Guidehouse has a large team of highly qualified staff members consisting of health and human services policy experts, clinicians, and former senior leadership from CMS, state Medicaid, health and human services agencies, health plans, and hospitals. The Guidehouse team has years of hands-on, managerial, and analytical experience. For over 30 years, Guidehouse has acquired extensive experience with program development, evaluation, and assessment, including actuarial analysis and program oversight.

Figure 3. Guidehouse Differentiators



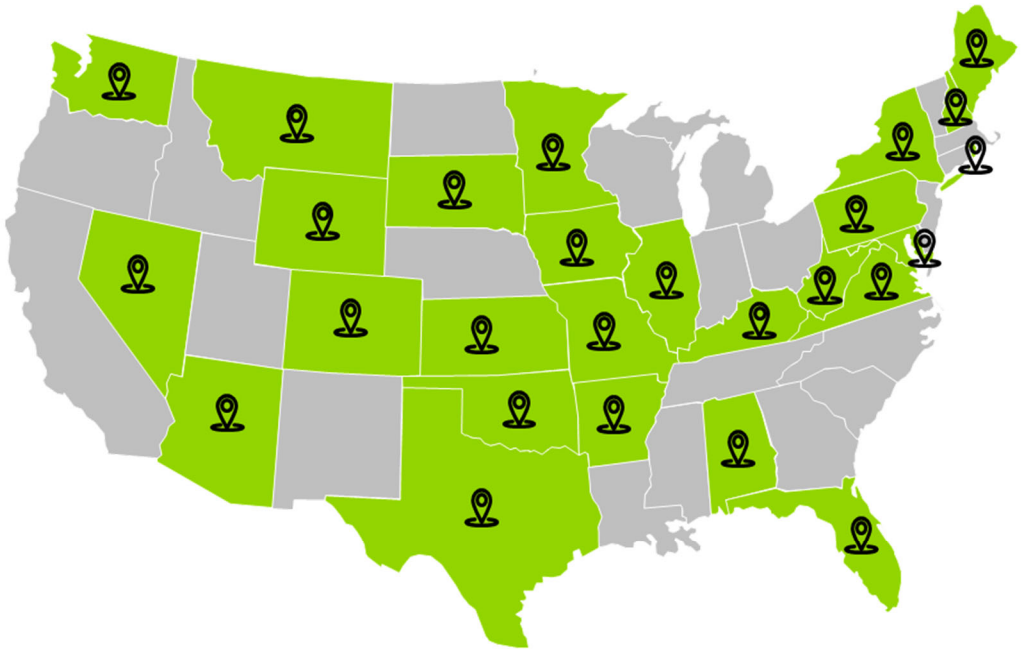
The Guidehouse team proposed to deliver this work has just under 100 years of cumulative experience supporting clients to make research and data-driven policy decisions, communicating decisions effectively to a variety of stakeholders (each with their own priorities and interests), and implementing policy, rate, or provider payment changes in an organized and cohesive fashion. We have included a matrix of our State Healthcare practice's relevant experience in social services, long-term care services, and developmental disability services in the following table.

Table 1. Sample Experience

	Relevant Experience	Nebraska	Alabama	Arizona	Arkansas	Kansas	Kentucky	Oklahoma	New Hampshire	Rhode Island	South Dakota	West Virginia
Service Fields	Social Services		X	X	X	X	X				X	
	Developmental Disabilities	X	X	X	X		X	X	X	X		
	Long Term Care	X	X	X	X	X	X	X	X	X	X	
Activity Experience	Literature Review	X					X	X				
	Stakeholder Engagement		X	X		X	X	X	X	X		
	Program Design		X		X	X	X		X	X	X	X
	Program Implementation		X		X	X	X					X
	Quality Strategy and Value-Based Strategies		X		X	X	X					X
	Clinical Integration											X
	Program and Policy Analysis	X	X	X	X	X	X	X	X	X		
	Legislative Reports or Communication Materials						X		X			
	Program Evaluation	X				X	X	X	X	X	X	

The Guidehouse State Healthcare Team has collaborated with health and human services agencies, including departments that serve people with I/DD. Over the past 30 years we completed projects with clients in nearly every state and as the map below shows, we have worked with just over half of all states within the United States in improving their LTSS/HCBS programs. We value our collaborations with these agencies and our relationships with the colleagues we support every day in the course of our work. We see our potential relationship with the Nebraska DHHS, DDD as another opportunity to be a colleague and collaborate for this engagement and beyond.

Figure 4. The following map represents 26 states where Guidehouse has provided expertise in various LTSS/HCBS improvement initiatives.



LEGEND						
Alabama	Florida	Kentucky	Missouri	New York	Texas	West Virginia
Arizona	Illinois	Maine	Montana	Oklahoma	Virginia	Wyoming
Arkansas	Iowa	Maryland	Nevada	Pennsylvania	Washington	
Colorado	Kansas	Minnesota	New Hampshire	Rhode Island	Washington DC	

We look forward to the opportunity to navigate the opportunities and potential challenges this engagement brings so we can support DHHS, DDD to improve the service delivery system for Nebraskans with I/DD.

2.B. Understanding of the Project Requirements

Section V.C.1. – Provide a narrative on how bidder will conduct assessment of independent living vs residential care.

Multiple contributing factors affect the Medicaid-funded continuum of care and the choices made by those individuals receiving that care. Clinical professionals, case managers / care coordinators, the mix of services, and the provider network quality and sufficiency all contribute to the decisions an individual and their natural supports make when choosing the setting in which they receive services.

To thoroughly assess a waiver participant's ability to execute the choice for independent living rather than congregate living DHHS will need to take the above factors into account. We propose the following approach for the assessment of waiver conditions that affect independent living versus residential care.

Guidehouse understands that Nebraska is a data-driven state and puts particular emphasis on data analysis and document review in our assessment approach. Following project initiation, Guidehouse will activate the environmental scan, literature review, and data analysis phase of the project to better understand Nebraska's current I/DD waiver population, programs, services, and needs. Using our proven research techniques, we will build upon our existing knowledge to supplement and strengthen our understanding of the current state of the waiver as it relates to independent living.

We will conduct an environmental scan to supplement and strengthen our understanding of the current waiver environment, with a specific focus on how individuals with I/DD select their preferred setting to receive services. This includes a review of documentation, data analysis, and interviews / focus groups with internal and external stakeholders. From a compilation of quantitative and qualitative information, we will be able to present data-driven recommendations to DHHS, DDD in the recommendations report.

Conduct Literature Review of Current Documentation and Policies

We will begin the assessment by gathering and reviewing pertinent waiver program documents and reports, and where necessary, conduct comparative analysis to similar and alternative state models to deepen our understanding of existing policies, procedures, regulations, and other program parameters that may impact independent living versus congregate living.

Guidehouse recognizes the Division's focus on this RFP is related to provider incentives to support independent living. However, our experience in prior assessments drives us to research the CDD waiver from a 360-degree viewpoint. There may be other drivers with equal impact affecting choice of setting.

We anticipate reviewing the following materials to gain a better understanding of Nebraska's current state:

- Relevant HCBS documents e.g., State Plan, CDD waiver, other related waivers or programs) that serve Nebraska's I/DD population and corresponding Nebraska Codes, Rules and Regulations, program manuals, and other available documentation
- Nebraska's ARPA Spending Plan, Olmstead Plan, and other strategic documents

- Contracts, policies, and procedures for the waiver providers that serve individuals with I/DD
- A sample of waiver assessments, person-centered plans, and other documents that provide context into how individuals choose their preferred setting to receive services.

Analyze Existing Program Data

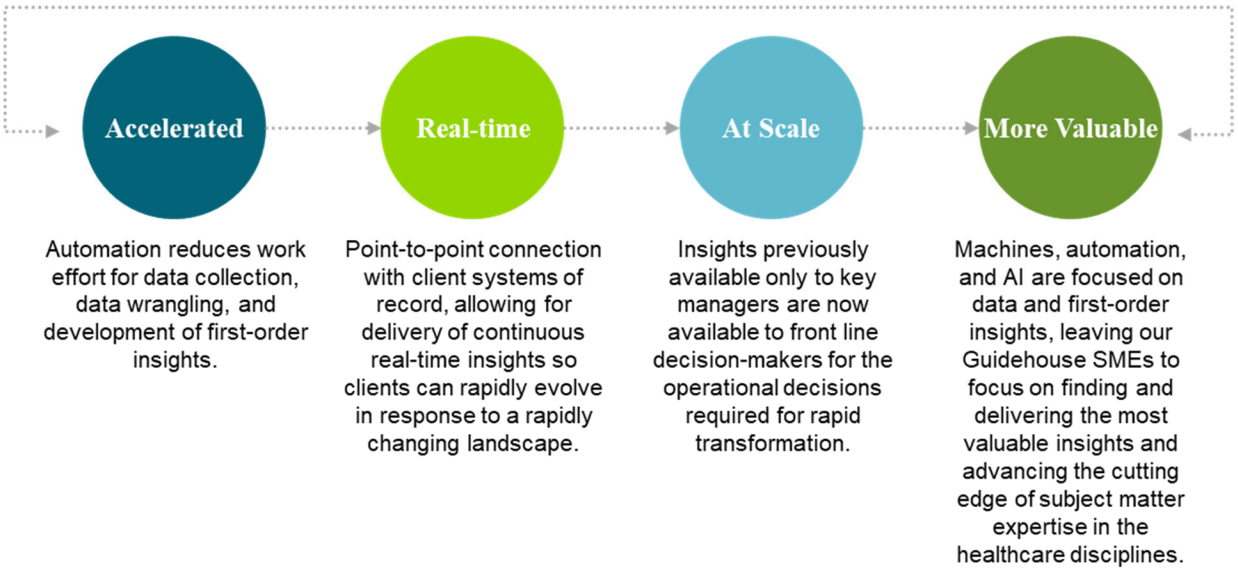
To complement our qualitative background knowledge, Guidehouse will review program billing / encounter, care planning, critical incident, and quality measure data to help us assess whether the CDD waiver program operates as intended, and to assess any gaps in service or benefit design that would need to be addressed to increase the number of individuals choosing independent living. This step allows our team to draw objective conclusions and theorize hypotheses about the key reasons for the choice of congregate settings in the CDD waiver program. These conclusions and hypotheses will inform Guidehouse as we develop the stakeholder engagement study activities later in the project.

Expanding on Nebraska's Data with Guidehouse (in)Sight Health™

We are also pleased to offer Nebraska access to proprietary and market-leading data tools beyond your Medicaid data, for use in the assessment. (in)Sight Health was developed at Guidehouse to support large, data-driven transformation projects that require extensive integration of public and private sector health market data that are delivered through leading change management practices. Guidehouse developed (in)Sight Health to help the United States Veterans Administration ("VA") understand markets across the US for each Veteran Integrated Service Network. The tool allowed the VA to better understand veteran preferences and goals in the context of a national planning strategy. We used (in)sight Health and other tools to better appreciate and form a national planning strategy for the VA to determine the needs for veteran homes versus other settings.

(in)Sight Health will offer DHHS, DDD access to a wide variety of public and purchased data sets, including commercial health and community analytics that may prove highly informative when conducting population analysis. We can then align the outputs of the data analysis with the assessment goals.

The platform leverages industry-leading subject matter expertise by combining it with "Big Data," analytics, predictive modeling, Web / Mobile software frameworks, and best practice design / implementation approaches. The result delivers healthcare insights that are:



(in)Sight Health™ Approach

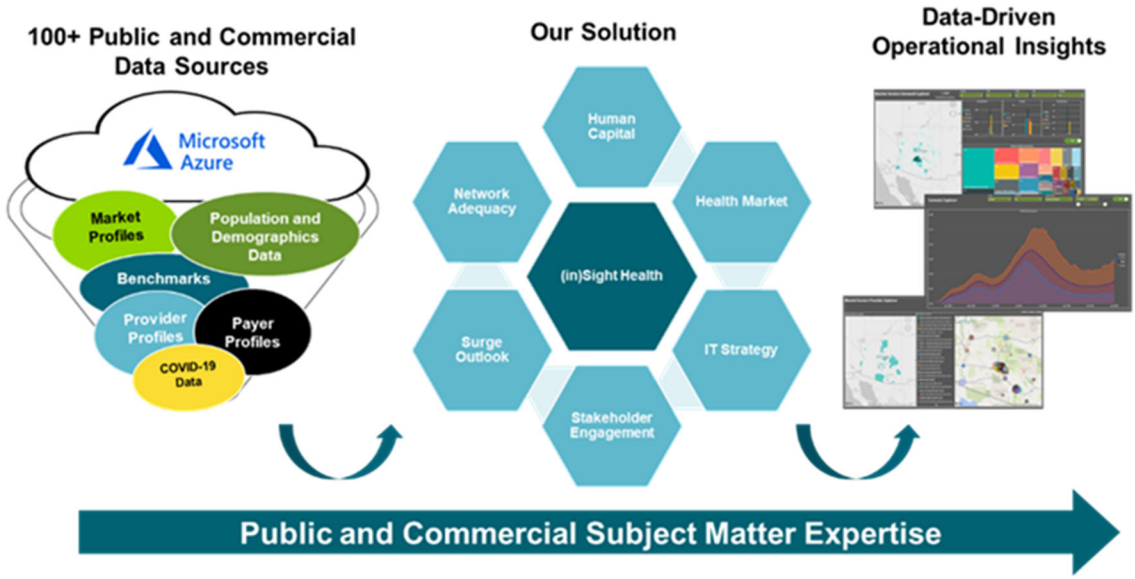
Using the State of Nebraska's supplied data, as well as other public and commercial datasets to which Guidehouse subscribes, we will leverage (in)Sight Health. (in)Sight Health is a proprietary, cloud-based powerhouse solution that harnesses a wide variety of public and private data, to deliver a rich analysis of the I/DD population and overarching community impacts to better "tell the story" of your home- and community-based population, and builds a data-driven case for our conclusions about the current state of independent living in the State and recommendations in improving provider engagement in establishing a successful congregate living program within the communities they serve.

(in)Sight Health leads the development and refinement of existing Guidehouse solutions in collaboration with client capabilities to accelerate customizable (in)Sight Solutions by leveraging:

- **Big Data** – Open Source and Commercial datasets are brought together in one secure cloud-based data warehouse tightly integrated with all other components that quickly access, use, and combine data to develop insights at scale.
- **Analytic Tools** – (in)Sight Health's service / microservice oriented architecture is agnostic and supports the use of best-in-class Open Source and Commercial analytic / languages so consultants can use and orchestrate the best and most appropriate analytic tools for each client need.
- **Cloud Delivery** – Insight delivery at the right place, time, and context are critical to impacting businesses. (in)Sight Health solutions can be delivered almost anywhere; Web, mobile devices, the Internet, or within other Cloud-based / legacy application contexts via application communication.
- **Best Practice Models** – Best practice models for strategy and transformation engagement (e.g., Market Health, Human Capital, Change Management) are available and can be customized for any specific client engagement and left behind to build an ongoing continuous improvement relationship.
- **Solution Construction** – (in)Sight Health provides a set of Cloud-based microservices for needs such as insight models, access control, data ingestion, and Web / IT /

Federated Application deployment. These services can be orchestrated to accelerate the development and implementation of new insight solutions. Guidehouse's (in)Sight Health Team offers a robust set of analytical capabilities and real-time data sources to transform data into insights and insights into solutions.

Figure 5. Scope of Public and Commercial Staff Expertise in Creating Data Driven Insights



Following these initial data reviews, collecting rich qualitative data via surveys and interviews will be imperative to determining a well-informed set of recommendations. Bringing quantitative and qualitative data elements together will offer a full circle view of Nebraska's current state.

Guidehouse will use the information collected through literature review, data analysis and staff expertise to develop an environmental scan that will set the stage for additional research and assessment**.**

Best Practice and Peer State Literature Review

In our experience with other states such as Kentucky, Oklahoma, and New York, we have developed a streamlined analysis and comparison process which results in a comprehensive approach to deliverable development that provides information to a wide audience in a manner that is detailed and easy to navigate. We will conduct detailed document reviews of **5 best practice states** based on performance (e.g., key performance metrics) and **5-10 peer states** with similar population, structure, and cultural dynamics as Nebraska to deliver a comprehensive, but targeted review of peers DHHS, DDD is most interested in. Guidehouse and the Department will determine the list of comparable states before research begins. This best practice and peer state research will include a detailed analysis of each selected state in up **to 15** predetermined and approved points of comparisons including:

These points of comparisons will be identified in collaboration with the State to promote targeted, balanced, and efficient research.

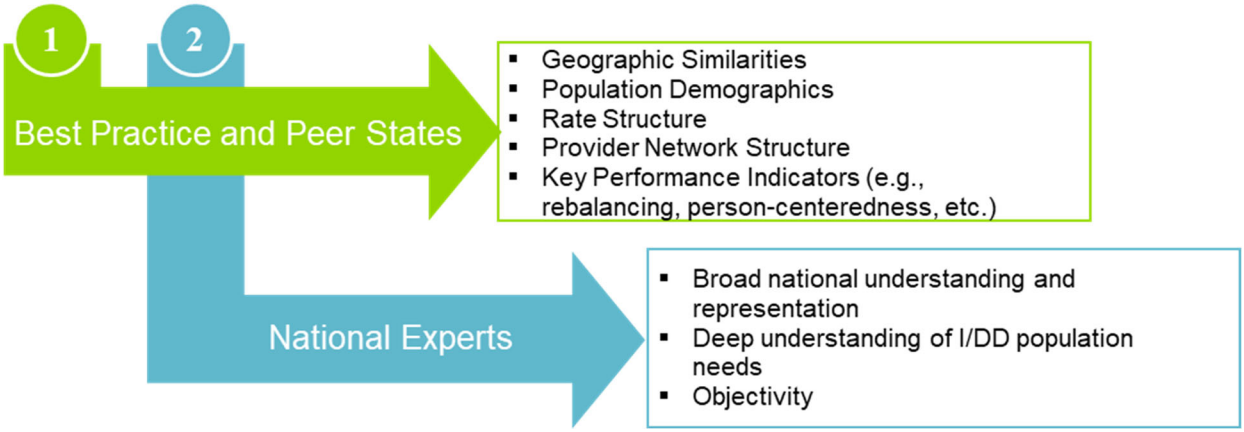
Guidehouse will summarize the results of the state policy analysis which will include examples of best practices, diverse payment / incentive methodologies, and innovative designs. Guidehouse will use its experience and existing resources developed through similar project work to evaluate our findings and include them in our report to DHHS.

National Expert Literature Review

Guidehouse continuously monitors emerging trends and issues in the HCBS space to keep our staff and clients up to speed. Our review will focus on recent publications reviewing national trends and best practices in LTSS, independent living, and the I/DD community. While we will conduct a targeted review for the purpose of the managed care study, we also have the capabilities to provide ongoing news trackers and target summaries of any new federal rules and regulations.

Our goal during the national expert literature review will be to catalog and summarize the latest best practices from informed and objective sources with targeted knowledge of the I/DD population and needs including ADvancing States, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and research organizations with specialties in LTSS.

Best Practice and National Expert Interviews



Upon selection of interviewees, Guidehouse will draft an invitation letter to secure the interviewee's participation; understanding that interviews may benefit from multiple participants with boots-on-the-ground experience with the day-to-day operations of waiver programs. Once an interviewee accepts the invitation to participate, Guidehouse will work with the interviewee to coordinate an interview. Interviews will be hosted virtually using a Zoom or Microsoft Teams platform and will last approximately one hour.

The research and information gathered in the best practice and national policy research will be used to inform question development for the expert interviews – to identify areas that may need further investigation or enhance our understanding of the population needs and innovated designs in service provision. We will also tailor these questions based on the best interviewees based on their experience (e.g., we will ask additional probing questions of states that transitioned I/DD waivers from congregate living to independent living, so we better understand the challenges and potential considerations).

While we will develop interview guides and provide sample questions to interviewees beforehand, our experience, most recently in Oklahoma, shows that initial questions open conversation, but organic conversation yield the most informative and fruitful feedback. We intend to use this semi-structured interview design that relies on a core set of predetermined questions but allows for flexibility within the interview to explore additional topics that may arise during the interview. Examples of these core set of questions are in the table below:

Table 2. Best Practice and Peer State Sample Domains and Questions
Providers
What do you see as challenges / barriers to independent living for I/DD population?
What experience / knowledge do you think is necessary for a provider to successfully serve the I/DD population in independent settings versus congregate?
What lessons learned can you share regarding your agency's approach for the I/DD population?
I/DD Population
What key components are necessary for the I/DD population to be served in the setting of their choice?
Overall, how well have 1915(c) waivers contributed to an individual with I/DD's ability to live in an independent setting in your state?
Federal Policy Trends

Table 2. Best Practice and Peer State Sample Domains and Questions
What are the emerging trends in independent living compared to congregate?
What are the most innovative diversion, transition, and independent living approaches?
What federal changes should we anticipate?
Best Practices
In your opinion, what is the most effective way to assure choice in setting for the I/DD population?
In your opinion, what is necessary for a well-operating waiver program to assure choice in setting?
Choice of Setting
Does the availability (or lack of availability) of accessible, affordable housing impact the choice in setting?
Are landlords and property management companies aware of the services available to individuals with I/DD that contribute to housing stability?
Does access to environmental modifications and / or assistive technology impact the choice in setting?

At the completion of the interviews, Guidehouse will provide an interim report to the State identifying themes, challenges, and best practices identified during the expert interviews.

Stakeholder Engagement

Meaningful engagement with diverse stakeholders is critical to gain a true 360-degree view of how the CDD waiver design and operations contribute to an individual with I/DD's choice in setting. Input provided by stakeholders helps the Department identify opportunities not otherwise observed by state staff and lead to more effective outcomes. There is a continued emphasis on collaboration between states and stakeholders prior to introducing changes, particularly those that would impact access to or quality of services that contribute to independent living. Guidehouse is an experienced collaborator who can support the Department throughout the CDD waiver assessment.

Stakeholder Engagement Documentation Review and Stakeholder Mapping

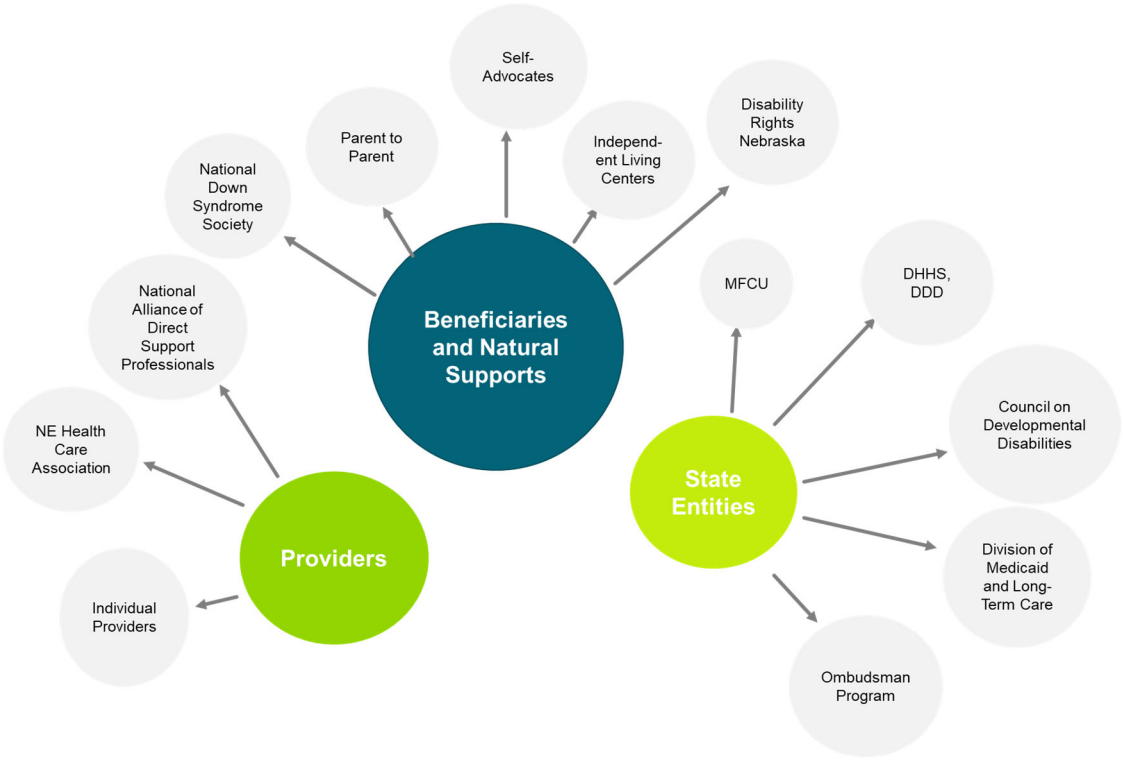
Guidehouse will begin by reviewing prior stakeholder engagement results of previous engagements by DHHS, DDD including stakeholder engagement summaries related to the most recent Family Support and Waiver Evaluation required by LB376 (if available). Our document review team will succinctly review all available notes, summaries, and comments regarding previous and ongoing stakeholder engagement activities related to the I/DD population. We will train our document review team to identify key themes based on agreed upon principles with the Department such as:

1. Comment or recommendation is within DHHS, DDD's jurisdiction and purview to create change
2. Comment is repeated multiple times by independent commentors
3. Comment is relevant to the stakeholder engagement aims and objectives

Through reviewing previous notes and stakeholder engagement results, Guidehouse will identify historical and emerging themes, key stakeholders, and a thorough background of engagement initiatives already undertaken by the DHHS. The results of the review will be used to inform stakeholder engagement methodology development of questions for future stakeholder engagement under this contract and to support development of a stakeholder map.

To develop a stakeholder map, Guidehouse will compile a list of key stakeholders from a variety of disciplines and types related to the waiver assessment objectives. We will review and include any of the stakeholder groups identified by the Department and Guidehouse to provide additional information specific to choice-in setting. We will then assess each stakeholder, or stakeholder group, to determine their level of familiarity and ability to impact the trajectory of the CDD waiver program. For example, a single provider may have high familiarity with the population and current program processes but low impact due to the small number of participants they serve. Stakeholder mapping can be presented in a matrix or cloud format as shown in the sample in Figure 6.

Figure 6. Stakeholder Mapping Sample



To round out and enable the Guidehouse team to ask targeted questions related to the assessment, Guidehouse recommends focused stakeholder engagement on three groups: participants and families, providers, and state staff. Advocacy groups and other stakeholders will also provide input through modalities that are less resource intensive than those described here (e.g., a state-wide survey posted on the DDD website).

Beneficiaries and Natural Support Engagement

Guidehouse proposes a participant-focused study of the CDD waiver to understand the implications of policy or program operations that affect choice in setting. Guidehouse staff have personal experience with, and are family members of, individuals with I/DD so we understand the importance of considering how policy changes at the state level will impact the participants' services.

To meet the goals and timeline set forth in the RFP, Guidehouse proposes fielding a **beneficiary and natural supports-focused survey** that can be made available online or in hardcopy to accommodate individual needs. The survey will use a mixed response type approach to collect detailed and valuable information quickly while leaving room for nuance and

personal experience. A sample of questions and response types can be found in the following table:

Table 3. Sample Questions for Beneficiaries and Natural Support Survey	Response Type
Indicate if a proxy was involved to support the respondent to answer questions.	Yes / No
Did you help pick the place you live?	Yes / No
How long have you lived here?	Number of months or years
Do you get the support you need to do the things you need to do each day? (Get out of bed, get a bath, etc.)	Likert scale (e.g., never, sometimes, often, very often)
What would you like to change about the place you live?	Free response

These questions will be developed in collaboration with DDD and upon final approval, will be sent to all participants in a format approved by the Division and that complies with State reading level requirements. Questions in the survey will be developed using input for the national policy scan research, results of the analysis of previous engagement results, and feedback from the project team and additional key stakeholders identified by the Division. Using quantitative response formats will enable us to analyze and detect themes quickly, while qualitative formats collect the fruitful detail needed to understand the participant and caregiver perspective. All survey results will be gathered electronically and aggregated for analysis via Microsoft Forms or Guidehouse's Qualtrics capabilities. While we are more than willing to provide the survey resources to capture this data, we understand the Division reserves the right to use its preferred electronic survey system.

Provider Engagement

This engagement spans across multiple providers and provider types and it is critical to involve these providers during the project life cycle. In addition to engaging individuals who receive services from DDD, Guidehouse will work with the Division to identify a comprehensive and diverse list of waiver providers, associations, and other provider stakeholders. As with participant and natural support engagement, Guidehouse proposes fielding a **provider survey** to collect information on the provider perspective. To effectively analyze the results and integrate provider feedback into the managed care study, Guidehouse also proposes using various response formats to streamline responses and capture detail such as the potential questions listed below:

Table 4. Sample Questions for Provider Survey	Response Type
On a scale of 1-10, 1 being least effective and 10 being most effective, how effectively do you think the provider network delivers supports the choice of care settings for individuals with I/DD?	Likert Scale
How would changes that increase the number of individuals living in an independent setting impact your organization?	Open-ended

The goal of these engagements is to assess and identify the quality and outcomes of the CDD waiver environment and to identify potential opportunities where the waiver design and implementation may support or hinder DDD in achieving its stated goals.

Guidehouse recommends surveys to quickly collect information from key external stakeholders and be able to organize and analyze data quickly. Survey data also allows us to easily quantify

results and identify themes across stakeholders with similar characteristics (e.g., the same provider type). While **Guidehouse recommends surveys for the purpose of the study, conducting additional stakeholder engagement activities to keep participants, caregivers and providers** informed and collect their feedback on the assessment and potential changes to the waiver will be beneficial on an ongoing basis.

State Staff Engagement

Supported by the information from documentation reviews and data analyses, Guidehouse will conduct a series of interviews to gain insight from internal state staff. We will work with project leadership to determine the right stakeholders to engage in this step. We also take a practical approach and use experience to guide selection – for instance, we always recommend including staff who are outspokenly critical, or might be change-averse. It will also be important to incorporate a mix of staff who have historical perspective as well as those new to state government to make sure we capture varying points of view.

We will begin with a series of targeted interviews of state agency staff across all levels, from front-line team members to senior executives. We anticipate conducting interviews with staff across the waiver operations and agencies. Guidehouse understands the importance in connecting with agency staff to identify opportunities that staff see to better collaborate across related agencies, understand cultural improvements, and gauge overall change readiness. We recognize that DHHS's people will make the difference when it comes to moving the system forward towards independent living. By getting to know your people, their perspectives, and change readiness, we can help to harness the impact of each employee and establish champions for your future strategy.

As summarized in the *Best Practice and National Expert Research* section of this response, Guidehouse takes a structured yet organic approach to interviews with clear objectives for the conversation and sample questions set beforehand but leaves room for the conversation to naturally take its course. To start the conversation, Guidehouse may ask questions similar to the following:

Table 5. Internal Stakeholder Sample Domains and Questions

Overall Waiver Performance
What CDD processes support an individual's choice in setting?
What data elements or reports do you use to assess whether waiver participants have active choice in their care setting?
Does the existing waiver service mix provide adequate supports for people with I/DD to live independently in their own home?
Provider Network
Are there differences in the availability of services across the state due to differences in provider service areas?
If so, are congregate services more readily available across the state?

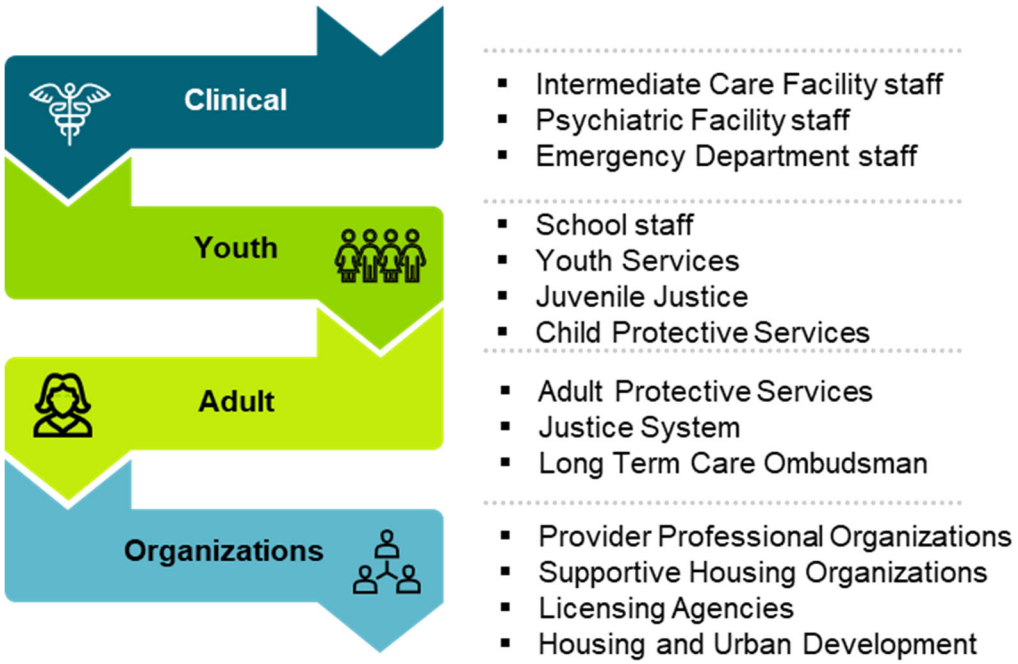
The stakeholder interview process will be critical for informing the broader I/DD service landscape. In addition to internal stakeholder interviews, additional external stakeholder needs will be met in the other *Stakeholder Engagement* subsections (participant, natural support, and provider surveys) and *Best Practice States and National Expert Research* sections of this response. For instance, we will also support and facilitate interviews with leadership in other

states and national experts as well as conduct a survey of external stakeholders within the state to gain an understanding of participant satisfaction and provider experience.

Guidehouse will use the results and findings of the engagement efforts with the various stakeholder groups and from the evaluation of prior stakeholder engagement in both the recommendations report. We will include all findings, including themes, strengths, and potential barriers as well as recommendations based on the findings to the Department.

Other Stakeholder Engagement for Consideration

Guidehouse also recommends conducting ongoing education and stakeholder engagement activities with the general public. In addition to the stakeholders outlined specifically for this study, other interested and involved parties that may be impacted by the assessment's results include the following:



Guidehouse is ready to assist the Department with any public statements, documents, or announcements to ensure the public is educated about the study or its results. Informing the public is particularly beneficial for policy and program initiatives involving the I/DD population. The I/DD population is a vocal and engaged group that is very active in policy decisions regarding their care. Continuous education efforts would provide DHHS the opportunity to explain policy decisions and gain buy-in from key stakeholder groups.

Section V.C.2. – Provide a narrative of bidder's practice of data collection and analysis.

Guidehouse has extensive experience collecting and analyzing qualitative and quantitative data. The approach we present will include qualitative data collection through robust stakeholder engagement and a literature review to identify best practices in sample states that effectively support independent living for individuals with I/DD over congregate settings. Additionally, we will engage our (in)Sight Health team to collect, analyze, and present data from our proprietary data sources. (in)Sight can create compelling visuals and interactive displays that allow DDD to review multiple scenarios using the same data set.

We discuss our methods in detail above in **Section V.C.1,** especially under the **Analyze Existing Program Data** heading.

Section V.C.3. – Provide a narrative of how the bidder will work with DDD to produce the report. The bidder may provide an example of previous work.

Guidehouse is well positioned to collaborate with DDD and identify opportunities for policy consideration, practice modification, or waiver amendments that promote waiver member independence in less restrictive living environments.

Within the initial assessment, Guidehouse will formulate an understanding of Nebraska's current CDD residential landscape, emerging strategies for incentivizing independent living from other states, and formulate an understanding for how current policy, and rates, shape and impact the residential living options. We will develop an initial draft report for DDD review within nine months of contract start. At the conclusion of the Initial Report, we will work with DDD leadership to review preliminary data, stakeholder engagement themes, and literature review findings and then continue the assessment and discuss ways to establish and refine recommendations into the Final Report.

Guidehouse Experience

Arkansas

Guidehouse worked with the Arkansas Department of Human Services, specifically the Division of Developmental Disability Services to provided regular legislative updates on our shared work implementing the state's ARPA 9817 HCBS Spending Plan.

Kentucky

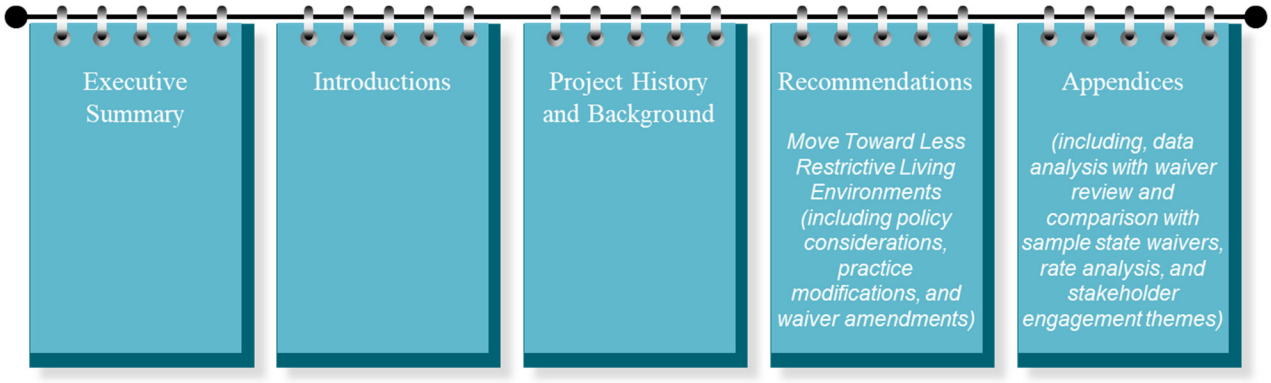
Guidehouse regularly coordinates with state agencies on the development of legislative updates and reports related to projects. We worked closely with the Kentucky's state Medicaid agency (SMA) to update the legislature on the progress of the 1915(c) waiver redesign during the length of the project.

Oklahoma

Our team is also deeply experienced with conducting objective waiver assessments informed by data and rooted in stakeholder feedback. Between March 2022 to March 2023, we worked closely with the Oklahoma SMA to conduct a 1915(c) Operational HCBS Waiver Analysis and developed a Final Report with nine policy and waiver amendment recommendations for State consideration.

While the initial report will offer preliminary recommendations and findings from the assessment, the Final Report will be based on comprehensive information and research collected throughout the entire project period. As Guidehouse prepares the Final Report and recommendations, we will work with the State to set program goals and explore additional recommendations and program requirements that yield results.

Guidehouse will develop a Final Report that documents the recommendations to incentivize independent living for waiver participants, assessment processes, and summaries of stakeholder engagement, literature and data review, and limited rate analysis. The Final Report may detail objective policy recommendations, practice modifications, or waiver amendments that Guidehouse recommends promoting independent residential living for CDD waiver members. We will collaborate with DDD to outline and structure the Final Report to include, at a minimum, the following sections:



Continual collaboration with DDD throughout the project lifespan will encourage the development of recommendations that are rooted in data, stakeholder feedback, and are practical for the State to pursue. We will also provide DDD with the opportunity to review the Initial and Final Report to provide consolidated edits for Guidehouse to incorporate in the Final Report.

However, our support for DDD throughout this engagement will stem beyond conducting the assessment and developing Initial and Final Reports. Guidehouse is prepared to serve as a communications and legislative engagement partner to prepare DDD to effectively communicate findings, recommendations, and next steps. From successful assessments we have performed in other states, we have also found it helpful to create shorter supplemental documents for Medicaid Directors, Legislators, and Governor's offices to provide a succinct snapshot of the recommendations, policy implications, and our analysis, along with what the fiscal impact will be to the state and providers. Providing this supplemental information is helpful to ensure that information is easily accessible for decision makers.

See Section V.C.5 for more strategies about how we propose to engage DDD throughout the assessment and report process.

Several Guidehouse (fka, Navigant Consulting, Inc.) led analyses and reports are publicly available including:

New York Office for People with Developmental Disabilities Managed Care Assessment Initial Report

https://opwdd.ny.gov/system/files/documents/2023/01/nys-opwdd-managed-care-assessment.pdf

Tennessee Healthcare Modernization Listening Tour Findings and Consideration

https://www.tn.gov/content/dam/tn/finance/documents/Findings.pdf

Alabama Integrated Care Network Concept Paper

https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.2_Other_Managed_Care_Programs/5.2.4_ICNs/5.2.4_Updated_ICN_Concept_Paper_3-26-18.pdf

We have also attached these in Appendix C.

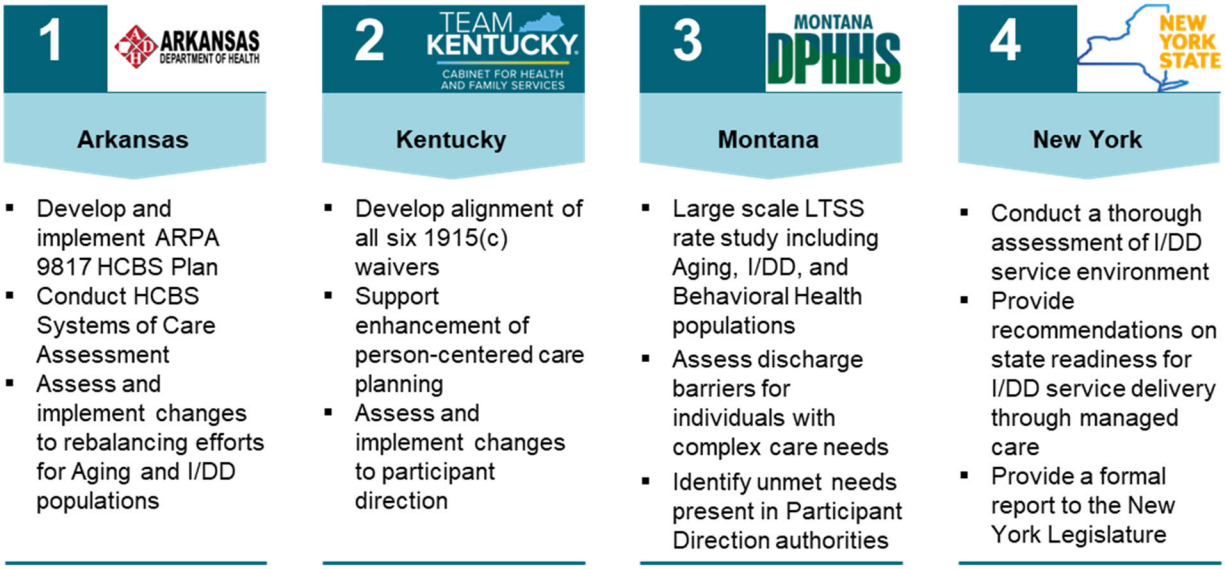
Section V.C.4. – Provide a narrative on the bidder's experience and knowledge on Comprehensive Developmental Disabilities (CDD) waiver experience

Guidehouse has extensive experience working with Medicaid populations, including I/DD in HCBS and LTSS settings. We are well equipped to assess waiver programs and gain an understanding of the changes needed to address our client's goals. We understand the complexities of providing services to the I/DD population and designing programs to innovatively address the complexities of care delivery.

Our team includes clinicians, practitioners, and social service professionals who have directly worked with individuals with I/DD. We bring our lived experience to bear when working with our clients; stakeholders find us relatable – which helps us gather impactful information and act as a trusted voice alongside DHHS, DDD. Given this experience, we can "read between the lines" of what we are hearing and learning throughout the assessment. We can help guide the Department through the challenges that invariably exist when addressing potential changes to waiver programs that serve a population that includes a passionate body of self-advocates and advocacy organizations.

As set forth in detail throughout this response, Guidehouse has more than 30 years' experience working with clients to support their Medicaid HCBS systems, including waivers. We provide highlights to our recent experience with clients below.

Figure 7. Experience in Assessment of 1915(c) Waivers



The experience in the four states above provides insight into the depth and breadth of our experience with 1915(c) waivers and transitions between care settings.

Throughout our response, we provided our proposed approach to the assessment of congregate care versus independent care. In addition, we wish to provide some insight into how we might approach an assessment of the CDD waiver, specifically. The questions we pose below are based solely on a review of the approved CDD waiver application. Our team will work closely with the Division to develop the project approach that takes all factors into account. We understand that publicly available information can only paint a small portion of the entire landscape of the waiver environment.

Table 6. CDD Waiver: Potential Research Questions

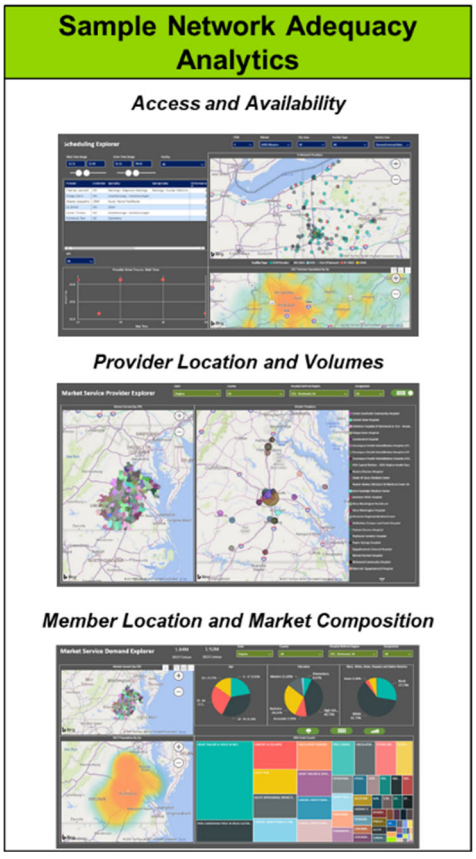
Table 6. CDD Waiver: Potential Research Questions
Do provider enrollment procedures contribute to the use of congregate settings?
Are enrollment processes different for congregate providers compared to providers for independent living services?
Participant Access and Eligibility
Do the priority criteria for selecting waiver entrants contribute to the use of congregate settings versus independent settings? For example, emergency placements are provided first priority for entry to the waiver. Does the emergency nature of those entrants relate to a higher use of congregate settings?
Participant Services
Do the provider requirements for delivery of services, such as licensure and / or regulatory compliance contribute to the use of congregate settings?
Are there changes / enhancements to service descriptions that could improve the use of independent settings?

Table 6. CDD Waiver: Potential Research Questions
Participant Directed Planning and Service Delivery
Does field level implementation of participant directed plans contribute to the use of independent settings? Are unmet needs related to the goal of independent living documented and addressed?
Participant Direction of Services
Would changes to participant direction allow for more individuals to use independent living services? For example, would the provision of certain services by legally responsible individuals allow for more participants to remain in family settings?
Quality Improvement Strategy
Would the inclusion of specific performance measures related to choice in setting support the increased use of independent settings?
Service Rate Estimates
Do current service rates, originally established in 2017 (with more recent updates), reflect the changes in the employment landscape, post-COVID? The current minimum wage in Nebraska is $10.50 and average entry-level wage for fast food services is over $12.00. Do current service rate differences between congregate and independent settings contribute to the use of congregate settings?

Performance Spotlight: (in)Sight Health™ in Action

Guidehouse can provide an assessment of the provider network through our proprietary (in)Sight Health™ platform. Guidehouse can use (in)Sight Health™ to help determine current service needs by looking at Nebraska's regional information, as well as service needs. Leveraging data from DHHS, our team has the ability to tailor our internal analytics and tools to review the statewide provider pool and identify potential gaps in network adequacy. The tools our team has available can quickly analyze:

- Provider access and availability
- Provider locations and relative volume share
- Member location and market composition



As a result of this activity, Nebraska could have a clear picture of the impact the provider network has on the use of congregate versus independent settings.

For example, when working with the Colorado Department of Health Care and Finance, we derived many benefits from our stakeholder engagement work with the state, advocacy groups, consumers, families, and providers. One benefit from these meetings was the development of geo-mapping tools to allow stakeholders to view provider offerings in their geographic area, but also see other providers available in the state including offerings that would allow for conflict-free delivery. Tools such as geo-mapping allowed stakeholders to better visualize service offerings in their area and provided visualizations to support rural access designations for those providers that were the only willing qualified provider in each area. The geo-mapping was a direct result of a comprehensive

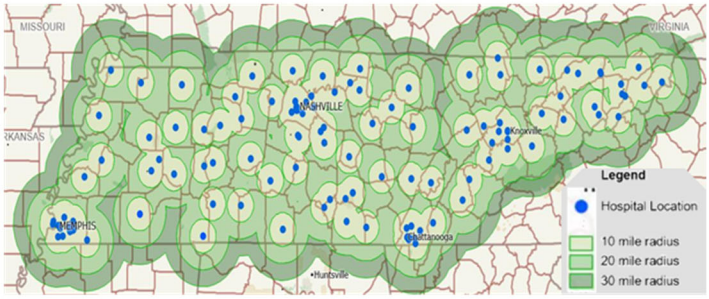
assessment of case management activities for consumers with developmental disabilities. Guidehouse conducted similar geo-mapping exercises for the State of Tennessee, highlighted below in **Figure 8**, in which we were tasked with assessing access gaps for acute care facilities. These mapping solutions have helped stakeholders identify providers in their geographic area, incentivize new providers to join state provider networks, and has led to further evaluations of rural service access and rural provider designations for purposes of complying with federal conflict of interest requirements.

Figure 8. Guidehouse Geo-mapping

Guidehouse's Provider Geo-Mapping Capabilities

Guidehouse has many years of experience plotting and analyzing the provider landscape and access to care on the state and local market levels. As part of the **Tennessee Health Care Modernization Task Force**, Guidehouse developed a comprehensive analysis and identified opportunities for the state to improve healthcare access for all Tennesseans. This analysis included mapping and assessing gaps in care, particularly access to acute care facilities as shown in the figure included in our recommendations to Tennessee.

Tennessee Acute Care Facility Location as of 2017

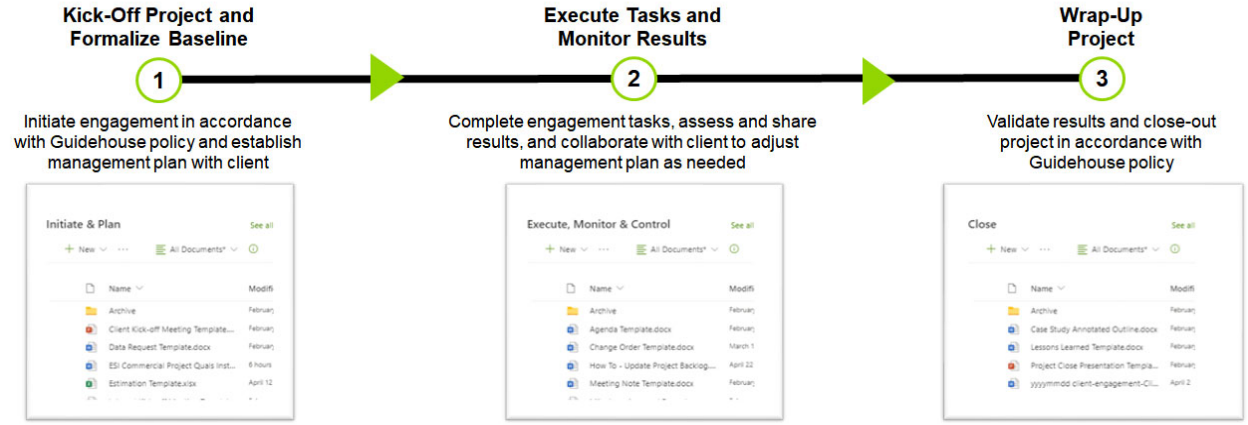


Section V.C.5. – Provide a narrative on how bidder proposes to collaborate with DDD throughout the process.

The Guidehouse project management team will implement an overarching project / program governance structure to ensure stakeholders and client leadership are appropriately involved in and informed about the status, progress, and direction of the effort throughout all phases of the lifecycle. We believe in proactively tackling and mitigating anticipated and emergent barriers using a combination of project management practices, consulting expertise and nimble client partnership. DDD can be certain that barriers both foreseen and identified will be quickly raised during standing status updates or via proactive communication with project leaders within the DDD team.

Throughout the entirety of this contract, Guidehouse's Project Manager, Amy Riedesel, will work closely with DDD to follow a rigorous project management schedule and work plan that details project activities and deliverables. Our Project Manager will oversee the limited rate analysis, data collection, waiver review and comparison with sample states, stakeholder engagement, and regular engagement with DDD leadership and staff, and collection of provider and recipient stakeholder input. Through our on-going status meetings, we will keep DDD apprised of our progress and collaborate on any challenges and resolution strategies. We firmly believe frequent communication and strong collaboration with DDD will be crucial to the success of the engagement and overall Final Report development. Figure 9 outlines our proposed project management approach.

Figure 9. Project Management Approach



Guidehouse will schedule regular bi-weekly status meetings with DDD via Microsoft Teams and attend planning meetings with DDD to provide progress reports on the work of this contract and to gather input on issues throughout our research and analysis. We will prepare and facilitate a project kickoff meeting with DDD after the project start date to discuss project goals, guide the collective DDD and Guidehouse team's work, and clarify roles and responsibilities.

Our initial kickoff meeting is essential for engaging with DDD leadership team from the start, communicating objectives and our approach, confirming the project timeline, and aligning expectations. The kickoff meeting is an effective way to foster communication with the project team. Our experience is that initial discussions like these help the project team anticipate and even head-off possible project challenges or barriers before they arise.

Guidehouse will create the agenda for the kickoff meeting and provide it to the DDD project manager prior to the kickoff meeting for approval. In addition, we will provide regular progress status reports that detail our ongoing activities, work completed to date, and project risks and their mitigation strategies.

The table below provides Guidehouse's recommended kickoff meeting agenda with topics and related goals along with a listing of related post-kickoff meeting activities.

Table 7. Recommended Agenda Topics and Related Goals

Agenda Item	Goal	Related Activities Post Kickoff Meeting
Draft Timeline and Proposed Work Plan	• Review proposed timeline and work plan and identify modifications / changes based on DDD input	• Finalize and submit the proposed work plan to DDD for approval. Should changes to scope or timing occur, we will provide an updated work plan on a bi-weekly basis
Project Governance Structure and Roles and Responsibilities	• Clarify channels of approvals required for key decisions in the project; this will avoid delays and allow team members to effectively deploy resources and avoid duplication • Identify DDD Project Lead who will be Guidehouse's single point of contact to facilitate approval of deliverables and	• Provide a listing of key DDD and Guidehouse staff and related roles and responsibilities

Agenda Item	Goal	Related Activities Post Kickoff Meeting
	activities and consolidate feedback from DDD into a single response • Identify additional DDD key staff and related roles / responsibilities (for example, related to information and data requests) • Review the roles and responsibilities of Guidehouse's team members and clarify as needed	
Project Management	• Review project management approach and obtain DDD feedback • Review monthly status report format and obtain DDD feedback	• Provide status updates via biweekly meeting agendas and post-meeting minutes
Data Requests	• Discuss potential data requests and needs, such as provider contracts and licensure agreements, annual reports, county-level Medicaid data and financial reports readily available to the Medicaid agency • Identify a DDD point of contact to assist with document and data request	• Search for publicly available information and initiate initial data request following project kickoff meeting
Deliverable and Invoice Submissions	• Confirm the expectations for timing, content and format of deliverables and invoices. We will provide one draft of each deliverable to the State for review and revise to present one final document, unless otherwise stipulated in our listing of deliverables	• To be determined based on the kickoff meeting

To facilitate timely information sharing and project management communication, our team uses regular status meetings to keep project leads updated on study progress while decreasing disruption to State staff. Guidehouse proposes holding biweekly status meetings. However, understanding the many demands on staff, in the event that a biweekly meeting agenda is light or there are no new topic areas for discussion, Guidehouse can furnish status updates via e-mail, and conduct follow-up coordination as needed. Guidehouse will update and maintain project management tools, as we appreciate our state clients are busy and do not want cumbersome, highly complex tools to navigate at the expense of other critical work you are responsible for.

The biweekly status meetings serve as a mechanism to discuss any issues that affect deadlines, review work plan updates, collaborate with DDD to obtain applicable data requests and provider agency points of contact. We will also use the biweekly meetings to brief DDD leadership on stakeholder engagement themes, data request findings, and innovative incentive mechanisms and preliminary recommendations based on the literature review.

Section V.C.6. – Provide a narrative on bidder's experience on assisting and implementing strategies to move towards least restrictive living environments to participants.

Below is a narrative representing one of Guidehouse's experience on assisting and implementing strategies to move towards least restrictive living environments to participants

Alabama Medicaid Agency

Contractor	Guidehouse Inc
Contract/Project Title	Alabama Integrated Care Network
Client Name	Alabama Medicaid Agency
Client Address	501 Dexter Ave, Montgomery, AL 36104
Project Timeline	January 2016 – November 2018

Description of Services/Scope of Work

Guidehouse worked with the Alabama Medicaid Agency to plan, design, and implement a LTSS program in coordination with CMS, called the Integrated Care Network program. The program was intended to improve the long-term care delivery system for older, Skilled Nursing Facility.

Medicaid beneficiaries, including individuals with Alzheimer's Disease and other dementias, individuals with HIV/AIDS and persons with physical disabilities. Guidehouse provided several workstreams of support to the Agency, including:

Program Design, Quality Initiative and Long-Term Care Education – Guidehouse assisted the Agency in designing and implementing a MLTSS like HCBS program, creating CFCM (integrated care network model), provided education and training in person-centered service planning, rebalancing, and the financial impacts of shifting care to community-based settings, care continuum, CMS' Managed Care Final Rule of 2016, federal HCBS conflict of interest requirements and HCBS Final Settings Rule.

Guidehouse also provided technical and analytic support for implementing the NCI-AD quality survey in the HCBS Program. Conducted Environmental Scan of LTSS Models – Guidehouse identified specific states to outreach on HCBS redesign initiatives.

Guidehouse also coordinated calls with various state leaders and conducted semi-structured interviews on behalf of Alabama Medicaid Agency leadership to better understand transitions from fee-for-service to other delivery models.

Stakeholder Engagement – Guidehouse facilitated stakeholder engagement on the design of the LTSS program and conducted 10 public meetings with the long-term care stakeholders, hosted two rounds of public input sessions, nine town halls meetings for consumers, caregivers, advocacy organizations and providers.

Results:

- **Due to nursing home diversion, the State observed $20M in overall cost savings in year one of program implementation, with $4M in state match savings.**
- **The program design included all area agencies on aging pursuing and obtaining NCQA case management certification to improve statewide care coordination for the SNF-eligible population.**
- **The ICN receives a per-member per-month payment, which is dependent upon reaching targets for the ratio of members using nursing facilities to members using HCBS. This is how the state has built a rebalancing incentive into the program.**

As stated throughout this response, Guidehouse has unmatched expertise in collaborating with states to implement strategies that make sure states create an environment where participants receive services in the least restrictive setting on the long-term care continuum. Whether we are

assisting states in implementing the HCBS Settings rule, advising on ways to facilitate rebalancing, assisting states in crafting, and implementing their ARPA plans, etc., our experience is unparalleled. Three of our proposed staff – Mark Thomas, Amy Riedesel, and Jayson Wright – have spent a good portion of their professional careers as public servants serving the population served by the CDD waiver and creating strategies to move persons to least restrictive settings. Many of our consultants also have lived experience, both in the public and private sector, in implementing strategies to support independent living. Below are three examples:

Mark Thomas (Project Director): Mark has supported the transition of individuals from institutional to home and community-based living alternatives in the public and private provider sector and has extensive experience implementing public policy rebalancing strategies at the local, state, and national level. As the leader of a private provider chapter of the ARC, Mark co-developed and managed the first Supervised Independent Living program in the state of Louisiana. As the President of The Louisiana Council of Executives of the ARC and the CO-Chair of the National Conference of Executives of the Arc Leadership Academy, he supported and provided technical assistance to dozens of providers on conversion from congregant setting models of care to home and community-based services. As Assistant Secretary of the Office for Citizens with Developmental Disabilities, Mark directed the design and implementation of the state's Money Follows the Person and Permanent Supportive Housing programs for the State's intellectual and developmental disability (I/DD) service delivery system. These programs promoted and prioritized the transitioning of individuals with I/DD from institutional living settings to homes of their own in communities of their choice. He also directed the design and implementation of the Supports and Residential Options Waivers which promoted transitioning from Congregate settings to community-based supported employment and the conversion of Intermediate Care Facilities to community-based residential options, respectively. Mark also played a prominent role on the downsizing of Louisiana's publicly operated facilities from 10 facilities to one. These rebalancing efforts and strategies decreased Louisiana's reliance on congregate and institutional settings by approximately 35% over the last 15 years.

Amy Riedesel (Project Manager): As a consummate leader in the work of long-term services and supports across populations, Amy has more than 18 years' experience building and leading successful community-based programs. Her work is founded in person-centered philosophy and true community inclusion for people with intellectual or developmental disabilities and aging and disability populations. She has been a state-level leader of transformational change of health and social programs.

In her adopted state of Georgia, Amy worked extensively with stakeholders and subject matter experts to establish Person-Centered Options Counseling program funded by the Money Follows the Person demonstration grant. Using the state's Aging and Disability Resource Connection ("ADRC") framework as a guide, Amy established the program from the "ground up" including a formal training and certification program, reporting processes, quality assurance, and technical assistance for the 12 ADRC Regions across the state. These Options Counselors were instrumental in the success of Georgia's rebalancing efforts and supported the creation of a state-funded mirror program to divert seniors not eligible for Medicaid from long-term placement in nursing facilities.

Jayson Wright (Subject Matter Expert): Jayson began his career as a Money Follows the Person ("MFP") Transition Coordinator, also in Georgia. In 2011, he brought his field expertise to the state level to support the training of transition coordinators across the state as the program manager for the aging / disability populations transitioned by MFP. Over the next seven years he would support the training, program management, and quality assurance activities

associated with MFP transition coordinators. In addition, he supported the development and implementation of a stand-alone data system to collect, analyze, and report MFP-related data. This data, with the support of advocates across the state, moved the Governor to create a state-funded mirror program to divert seniors not eligible for Medicaid from long-term placement in nursing facilities.

2.C. Proposed Bidder Requirements Approach

Section 2.C.1 – Assess the overall environment of independent living versus 24-hour residential care.

Guidehouse recognizes the importance of understanding the independent and 24/7 residential care environments in Nebraska as well as other states. We will schedule a meeting with Nebraska leadership to discuss and agree upon additional states' services to review, based on performance (e.g., key performance metrics), similar population, structure, and cultural dynamics as Nebraska. We will deliver a comprehensive, but targeted review. Guidehouse will summarize the results of the state policy analysis which will include examples of best practices, diverse payment methodologies, and innovative designs. The Guidehouse team will use its experience and existing resources developed through similar project work to evaluate our findings and provide a summary report to Nebraska DHHS.

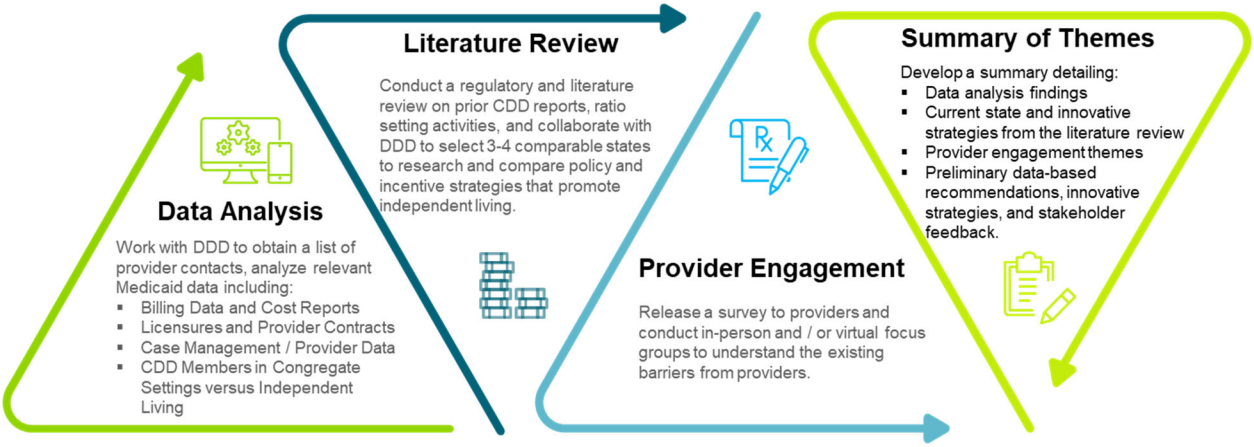
Guidehouse understands that Nebraska is a data-driven state and puts particular emphasis on data analysis and document review in our assessment approach. Following project initiation, our team will activate the environmental scan, literature review, and data analysis phase of the project to better understand Nebraska's current I/DD waiver population, programs, services, and needs. Using our proven research techniques, we will build upon our existing knowledge to supplement and strengthen our understanding of the current state of the waiver as it relates to independent living.

We discuss our proposed approach in more detail in *Section V.C.1*.

Section 2.C.2. – Conduct an assessment on the barriers to agency providers making the move towards independent living.

Guidehouse understands that Nebraska offers a wide array of residential offerings to CDD waiver participants, including 72 Centers for Persons with Developmental Disabilities and numerous group homes that provide continuous, 24-hour care. Following project initiation, we will conduct an analysis of relevant Medicaid data, engage in relevant literature review, and embark upon the stakeholder engagement phase of the project to better understand Nebraska's current CDD waiver, programs, services, provider network, barriers, and needs. Using our proven research techniques, we will build upon our existing knowledge to supplement and strengthen our understanding of the current state of Nebraska's congregate residential care settings and comprehensively identify challenges, perceptions, and barriers to moving into independent living options. Figure 10 provides an overview of our overall provider agency assessment process.

Figure 10. Provider Agency Assessment Process



Analysis of relevant Medicaid Data & Literature Review

Guidehouse will analyze Medicaid data including, but not limited to billing data and cost reports, provider contracts, case management and provider data, and county-based Medicaid data that depicts the number of CDD waiver participants in congregate settings and independent living settings.

Guidehouse will conduct a literature and regulatory review of Nebraska's prior reports, rate setting activities, residential credentialing and licensure standards, and other laws or regulations that govern residential living arrangements for CDD waiver participants. We will also examine other best practice and comparable states to determine what strategies have been utilized previously to incentivize the transition to independent living as opposed to congregate care.

For more information about the data analysis and literature review process see *Section 2.C.3.*

Provider Engagement

Meaningful engagement with diverse stakeholders is a key component of this engagement. Input provided by stakeholders helps the state identify opportunities not otherwise observed by state staff and lead to more effective recommendations and desired outcomes. There is a continued emphasis on collaboration between states and stakeholders prior to introducing changes, particularly those that would impact access to or quality of services. Guidehouse is an experienced ally who can support the State throughout the assessment and possible implementation of proposed recommendations that incentivize independent living for CDD waiver participants.

Provider agency engagement will be crucial to understand the current state, barriers, and future state of transitioning CDD waiver participants from congregate to independent living settings. Guidehouse will work with DDD to develop a list of provider agencies then develop a provider survey to harness input from the residential providers.

Survey

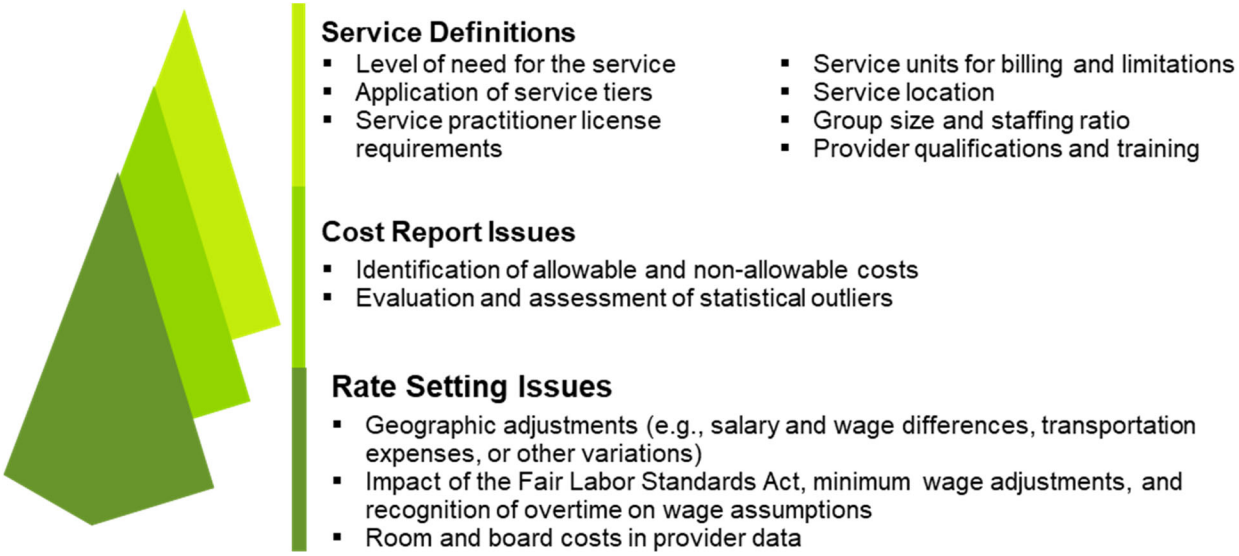
Our Guidehouse team has developed and executed provider surveys in more than a dozen states and we believe developing a survey will allow us to gather the data necessary from providers to support identification of barriers and development of potential rate setting and incentive recommendations.

We will kick-off this task with a collaborative discussion with DDD about Nebraska's CDD residential waiver service definitions to allow us to fully understand service requirements, activities, staff requirements, etc., which will inform decisions about what data is necessary to collect from providers. Next, we will develop the Provider Survey and instructions, administer the survey, verify responses with providers and finally, conduct analyses of the survey data to be summarized in a report to DDD.

Guidehouse will use the information learned from our conversations with DDD and other research about the service definitions, requirements (e.g., provider qualifications, training requirements, etc.), previous incentives, and prior stakeholder engagement to serve as a basis for the development of the Provider Survey. We understand that some of the information we will want to discuss is readily available in waiver applications and provider manuals; however, we find that candid discussions unveil certain nuances or system work arounds that are not documented by states, such as specific staff credentialing requirements that may be unique to specific services. Through our work with other states, we have found that an in-person discussion with state staff provides the ideal means for confirming our understanding of each service.

Guidehouse will facilitate a discussion with DDD that reviews each waiver service to understand some key components critical to the Provider Survey, these will include:

Figure 11. Provider Survey Key Components



Guidehouse has extensive and recent experience conducting surveys, including Provider Cost and Wage Surveys, of HCBS providers. We know the common issues that arise when providers complete surveys to report cost and wage data (e.g., verifying the level of granularity of cost data providers are able to report, isolating costs of a particular program or reporting of costs, and identifying wages when staff provide multiple functions).

Based on our conversations with DDD, we will develop an initial provider survey that we will share with DDD for approval. Sample survey questions are listed in *Section V.C.1*. We will also provide detailed instructions, or training, to providers on how to complete the Provider Survey, to promote the submission of accurate and usable data from providers that will help inform potential incentive rate recommendations.

Guidehouse assumes that DDD will be able to provide Guidehouse with the contact information of providers that should participate in the Provider Survey and we will work with DDD and provider associations on outreach strategies to attain a satisfactory level of participation. We recommend releasing the Provider Survey via email from a dedicated Guidehouse email address. We will provide technical assistance and support for providers through the same dedicated email address.

Focus Groups

Supported by the information from documentation reviews and data analyses, Guidehouse will conduct a series of focus groups to gain insight from residential provider agencies. We will work with project leadership to determine the right stakeholders to engage in this step.

We will begin with a series of five in-person focus groups of residential providers in five regions of the state. We also anticipate conducting up to three virtual focus groups for those who cannot attend in person. Guidehouse understands the importance in connecting with residential provider agency staff to identify opportunities that staff see to better transition CDD participants into independent living settings, understand existing barriers in doing so, and gauge overall change readiness. By getting to know your provider agencies, their perspectives, and change readiness, we can help to harness the impact of provider agencies and establish champions for your future incentive strategy.

Guidehouse will work with DDD and their department's communications team to secure focus group locations and disseminate messaging to provider agencies at least two months in advance of the meetings. We will work closely with DDD to develop branded messaging to include email templates, social media posts, or website banners.

Guidehouse takes a structured yet organic approach to focus groups with clear objectives for the conversation and sample questions set beforehand but leaves room for the conversation to naturally take its course. To start the conversation, Guidehouse may ask questions similar to the following:

Table 8. Provider Agency Focus Group Domains and Questions

Current State
What do you see as challenges / barriers to independent living for the CDD waiver population?
What lessons learned can you share regarding the transition to independent living from congregate care for the CDD waiver population?
CDD Waiver Population
What key components are necessary for the I/DD population to be served in an independent living setting?
Overall, how well has congregate versus independent living settings served the needs of individuals with I/DD in your state?
Future State
What is the level of effort for your agency to transition CDD waiver participants from congregate to independent living?
What would be helpful to assist with this transition, or what would you like to see from the State?

Guidehouse will staff each focus group with at least one notetaker and one facilitator. We will take notes transcription style and de-identify all responses from participants. Following the focus

groups, our team will compile, and sort responses based on common themes and will share the results with DDD.

Summary of Themes

Guidehouse will use the results and findings of the engagement efforts with the various stakeholder groups and from the evaluation of prior stakeholder engagement in both the Initial Report to DDD and the Final Report. We will include all findings, including themes, strengths, and potential barriers as well as recommendations based on the findings to the State.

Section 2.C.3 – Gather, plan, and examine the current data.

Guidehouse will review program encounter, care planning, critical incident, and quality measure data to help us understand whether programs are operating and serving HCBS and MLTSS members as intended, and to assess any gaps in service or benefit design that would need to be addressed. This step allows our team to draw objective conclusions and theorize hypotheses about the level of preparedness Nebraska's I/DD programs have prior to reducing reliance on congregate care. These conclusions and hypotheses will inform and be tested by the stakeholder engagement study activities and serve as a "source of truth" for the development of deliverables.

Guidehouse Experience

Data Analysis for the Association of State and Territorial Health Officials (ASTHO)

Guidehouse is supporting ASTHO, in collaboration with the United States Centers for Disease Control to conduct multi-state Medicaid data analysis and develop a peer-reviewed public health journal manuscript for a study of COVID-19 impacts on service utilization among persons with I/DD across five states, collaborating with the Centers for Disease Control . This collaborative engagement gives us firsthand insight into Centers for Disease Control and public health perspectives on post-pandemic preparedness planning for the population, which is highly relevant to Nebraska's 1915(c) waivers.

As stated above, Guidehouse will offer DDD access to proprietary and market-leading data tools for use in the assessment of strategies. (in)Sight Health™ was developed at Guidehouse to support large, data-driven federal transformation projects that require extensive integration of public and private sector health market data and human capital data that are delivered through leading change management practices. (in)Sight Health will offer DDD access to a wide variety of public and purchased data sets, including commercial health and community analytics that may prove highly informative when conducting analysis. We can then align the outputs of the data analysis with DDD's strategic goals and quality considerations.

Section 2.C.4 – Identify and examine existing data sources.

Guidehouse will tailor its approach in conducting evaluations and assessments by first identifying and defining Nebraska's requirements and study objectives, followed by employing a combination of analytic tools and research methods that are better suited to achieving those objectives. Our team decreases the timeline to collect data by leveraging existing templates, tools, technology, and processes, which are leading practices applied in program evaluation studies. Our tools will be tailored to address the unique needs and nature of Nebraska DHHS work and operating environment.

Guidehouse knows data analysis. Our team leverages data sources, including publicly available and client-provided data, to conduct in-depth analyses that inform decision-making and drive the understanding of problems and subsequent solutions. We also leverage internal data analytic tools, such as the (In)Sight Health™ tool, and solutions to help our clients make operational and

strategic decisions. Examples of our robust experience with data analysis, including commercial market analytics and Medicaid actuarial services, that informs our program evaluation and quality improvement strategies are discussed in the following table.

Table 9. Guidehouse Sample of Data Analysis Services

Client	Data Analysis Services
TN Department of Economic & Community Development	From 2019 to 2022, Guidehouse supports the Tennessee's Rural Hospital Transformation Program **to assess financially distressed rural hospitals and provide transformation plans that improve sustainability.** In addition to transformation plan development, Guidehouse supports the subsequent provider reporting and data analytics to monitor the program impact. **Guidehouse leveraged self-reported information from participating hospitals paired with Medicaid Cost Report data (i.e., HCRIS) to assess the program impact.** The reporting results are summarized biannually and identify lessons learned throughout the program, short-term program adjustment recommendations, and long-term policy recommendations to the State for consideration. Guidehouse identified over **$8M in annual revenue generation and over $4M in cost savings across 14 participating hospitals**. Additional Guidehouse data analysis identified the key impacts of the program, including participating hospitals demonstrating more financial resilience during the early stages of COVID-19 compared to non-participating hospitals.
WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES	From 2020 to 2022, Guidehouse supported the State of West Virginia Bureau for Medical Services, the State's Medicaid agency, in managing and monitoring the State's Medicaid managed care programs. **Guidehouse's support included monitoring managed care organizations contractual compliance, financial, quality, and utilization reporting, development of interactive managed care oversight dashboards via our Salesforce capabilities. In addition to reporting activities, Guidehouse supported the programs actuarial activities, including in-depth data analysis and actuarially sound rate setting methodologies and programmatic strategy,** including developing the State's managed care quality strategy**,** submitted 1915(b) waiver renewals and federal reporting and direct provider payment program framework and operations.

Additionally, leveraging relationships and knowledge from within Guidehouse, we will evaluate best practice models for transitioning systems to a focus on independent living among a diverse array of states to gain comparative insight on their existing model and structure.

Section 2.C.5. – Develop and assist with strategies to implement incentives for agency providers to find independent living or least restrictive living environments.

Guidehouse will complete a thorough assessment to develop successful and sustainable strategies by assessing the impacts of independent living or least restrictive living based on structure, process, technology, and people impacts. Guidehouse will prepare and submit recommendations based on its assessment and the data it develops that will guide Nebraska DHHS to reduce reliance on congregate care.

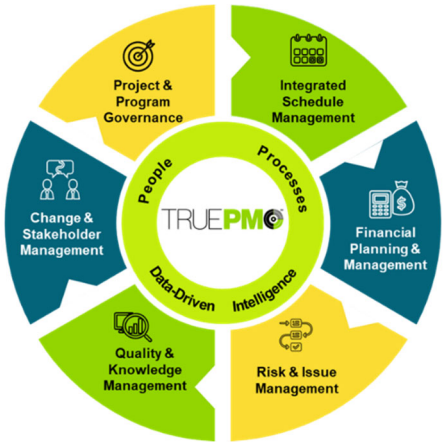
Once the data has been reviewed, Guidehouse will generate a number of strategies based upon established best practices to incentivize providers to find independent living or least restrictive living environments. These best practice solutions will take into account the unique needs of DDD's provider pool and the conditions through which they will be able to shift the emphasis to independent living. Incentives for making the shift to independent living will likewise be tailored to the unique needs of DDD's provider pool, recognizing that behavior change at the individual or systemic level only takes place when there are clear self-interested reasons for doing so. Guidehouse will identify common motivators for systemic change among providers of therapeutic housing services to those with developmental disabilities.

These motivators / incentives will then be paired with an implementation strategy that will include at a minimum, strategic communications, training / education materials for families of those impacted, referral guides for independent living options, assessment tools to determine those who would most benefit from independent living, and press kits with visuals to highlight the benefits of transition to independent living for persons with developmental disabilities. The implementation strategy will be an iterative process, considering lessons learned in operation and making adjustments as needed to account for the lessons learned. The strategy will also have an evaluation component inclusive of establishing and tracking both process and outcomes measures. These measures will be vetted with DDD and Guidehouse will establish data capture tools to track progress (process) and results (outcomes).

2.D. Detailed Project Planning and Management Plan

Project Management

Guidehouse will leverage its project management office (PMO) methodology, **TruePMO℠**, which has been developed and refined over thousands of engagements and is designed to improve efficiency, mitigate risk, and realize value at every stage of the project. There is no one-size-fits-all approach to developing a PMO; we will tailor our PMO solution to DDD's specific needs and goals.



Given the importance of this type of engagement, we believe that setting up the project correctly from the outset is critical.

The following represent the core project management activities that we will complete during this project:

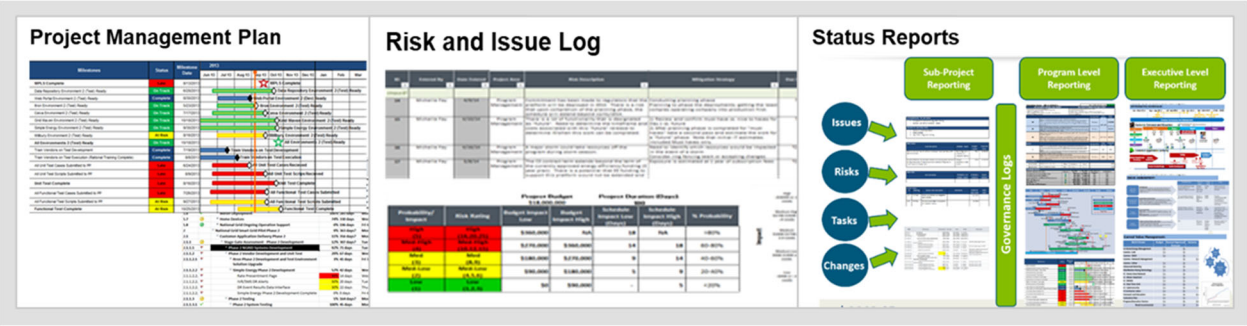
Conduct project review and refine our project work plan. We will kick off this engagement with a focused planning session with DDD to refine our Work Plan, establish a communication cadence, and equip the team with the resources needed to deliver the value you expect from Guidehouse. Our project work plan dictates the implementation timeline, activities, dependencies, and resources needed. This will establish clear expectations for all involved and help all parties work toward a common goal. Our project management plan is critical to ensuring that the various workstreams and organizational change strategies are aligned with the DDD's intent, timeline, and objectives.

Workstream planning, management, and execution. Workstream planning focuses on prioritizing project activities and milestones, while ensuring coordination between Guidehouse and DDD. During all phases of the project, Guidehouse will facilitate clear, consistent, and frequent communication with DDD to keep staff and stakeholders informed of what is happening throughout the project.

Guidehouse will also maintain and provide the following tools to support our project management activities.

Report Name	Report Description	Reporting Frequency
Project Management Plan	Detailed Project Work Plan outlining all activities and progress for a particular task / subtask	Weekly
Decision-Making Log	Tracking log for decisions to allow for an updated repository of prior decisions	Updated as decisions are made
Risk and Issue Log	Elevate potential risks and mitigation strategies as work continues	Bi-weekly and upon request
Meeting Agendas and Minutes	Weekly agendas, summaries, and action items from each meeting	Weekly (or as meetings occur)
Program Level Status Reporting	Communicates project updates, risks, issues	Frequency determined by DDD
Executive Level Dashboard	Executive level dashboards	Frequency determined by DDD

Figure 12. Sample Project Management Tools



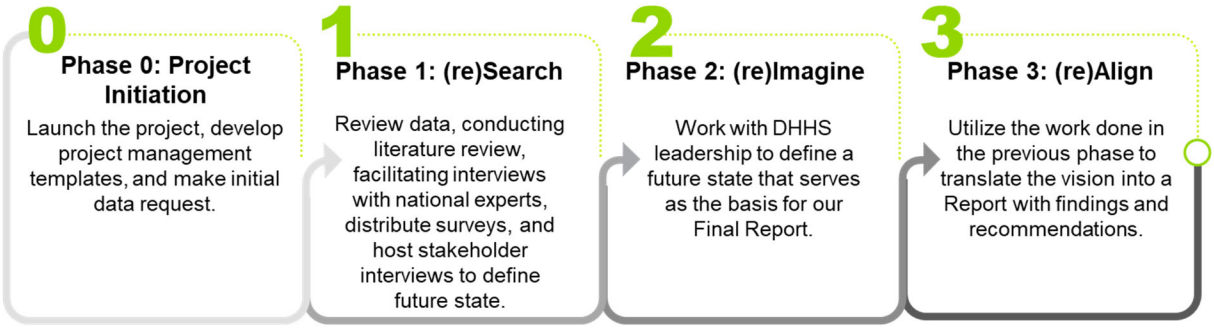
Organizational Change Management

> Our Guidehouse team is purpose-built to integrate IT and health and human services experts who have "been in your shoes" with organizational design and change management experts who can implement industry best practices to our strategic assessment and reorganizational services.

Effective organizational change management (OCM) will be critical to the success of this project.

Guidehouse has developed the scientific, interdisciplinary ***(re)Vision***^{TM} change management solution to help our clients actively plan for and manage the human dimensions of large-scale organizational transformation. Our *(re)Vision* approach goes beyond traditional change techniques and gets into stakeholders' minds during each phase of the engagement to truly change behavior.

Our tested approach utilizing *(re)Vision* is made up of the following phases:



The Guidehouse team will organize weekly team check-in meetings, submit weekly progress reports outlining activities and milestones, maintain an updated project schedule, and manage an "open issue" log to quickly raise any potential risks or roadblocks so that they may be addressed quickly.

Figure 13. High-Level Change Management Approach

	Phase 1 Project Initiation	Phase 2: Analysis of Current State	Phase 2: Envisioning Future State
Purpose	Confirm project goals and objectives with DDD	Assess current state and identify steps for DDD to take to help teams and providers move towards less restrictive residential settings	Conduct an assessment and synthesize findings into a Report
Key Activities	• Review work products timeframes, and project plans • Conduct kick-off meeting	• Review relevant data and documents • Review national expert literature • Conduct interviews with selected national experts • Distribute beneficiary and provider surveys • Facilitate stakeholder interviews	• Generate recommendations based on environmental scan, state policy analysis, stakeholder activities • Review with DDD preliminary data, stakeholder engagement themes, and literature review findings and then continue the assessment and discuss ways to establish and refine recommendations into the Final Report • Develop Final Report
Deliverables	• Project kick-off meeting • Project Management Plan with associated milestones and timelines	• Project Review • Environmental Scan • Survey Results • Interviews with selected national experts	• Assessment • Initial Report • Final Report
Project Management and Communication			

Project Work Plan

Proposed Project Timeline		Contract Period *(Months)*																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.0	**Project Management**																		
1.1	***Project kickoff***																		
1.1.A	Schedule project kickoff meeting																		
1.1.B	Prepare project kickoff materials																		
1.1.C	Facilitate project kickoff																		
1.2	**Ongoing project management**																		
1.2.A	Establish and facilitate ongoing biweekly status calls																		
1.2.B	Monitor project progress and track timelines																		
1.2.C	Identify and mitigate risks																		
2.0	**Environmental Scan, Literature Review, and Data Analysis**																		
2.1	***Internal DDD Data Review***																		
2.1.A	Gather and review waiver program documents and reports																		
2.1.B	Conduct comparative analysis																		
2.1.C	Review program billing / encounter, care planning, critical incident, and quality measure data																		
2.1.D	Gather qualitative data through interviews and surveys																		
2.2	***Best practice and peer state literature review***																		

Proposed Project Timeline		Contract Period *(Months)*																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
2.2.A	Consult with DDD to identify 5 best practice states																		
2.2.B	Consult with DDD to identify 5-10 peer states																		
2.2.C	Document review of best practice states																		
2.2.D	Document review of peer states																		
2.3	***National expert literature/best practice review and interviews***																		
2.3.A	Review recent publications reviewing national trends and best practices in LTSS, independent living, and the I/DD community																		
2.3.B	Establish ongoing news trackers and target summaries of any new federal rules and regulations																		
2.3.C	Consult with DDD to identify national experts to be interviewed																		
2.3.D	Develop and distribute communications to national experts selected																		
2.3.E	Confirm and schedule interviews with selected national experts																		
2.3.F	Develop interview discussion guides and validate with DDD																		
2.3.G	Conduct interviews with national experts																		
2.4	***Stakeholder, Beneficiaries, and Natural Support Engagement***																		
2.4.A	Review prior stakeholder engagement results of previous engagements by DDD																		
2.4.B	Identify key themes based on agreed upon principles with DDD																		
2.4.C	Develop a stakeholder map																		
2.4.D	Assess each stakeholder, or stakeholder group, to determine their level of familiarity and ability to impact the trajectory of the CDD waiver program																		

	Proposed Project Timeline	Contract Period *(Months)*																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
2.4.E	Conduct a beneficiary-focused study of the CDD waiver																		
2.4.F	Field a beneficiary and natural supports-focused survey																		
2.4.G	Work with DDD to identify a comprehensive and diverse list of waiver providers, associations, and other provider stakeholders																		
2.4.H	Field a provider survey to collect information on the provider perspective																		
2.4.I	Develop an interview guide for state staff stakeholders																		
2.4.J	Conduct a series of interviews with state staff stakeholders to gain their perspective																		
2.4.K	Conduct ongoing education and stakeholder engagement activities with the general public																		
3.0	**Prepare and deliver initial draft report**																		
3.1	***Review and synthesize findings into an assessment***																		
3.1.A	Develop and document full circle view of Nebraska current state through synthesizing findings of the internal data review into an environmental scan																		
3.1.B	Summarize results of the state policy analysis including examples of best practices, diverse payment methodologies, and innovative designs																		
3.1.C	Provide an interim report identifying themes, challenges, and best practices identified during the interviews with national experts																		
3.1.D	Provide an interim report identifying themes, challenges, and best practices identified during stakeholder engagement activities																		
3.1.E	Work with DDD leadership to review preliminary data, stakeholder engagement themes, and literature review findings																		
3.2	***Develop the initial report***																		
3.2.A	Generate preliminary recommendations and findings from the assessment																		

Proposed Project Timeline		Contract Period *(Months)*																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
3.2.B	Document findings into the initial report																		
3.2.C	Conduct an overview meeting with DDD to discuss findings of the initial report																		
4.0	**Prepare and deliver final report**																		
4.1	***Develop the final report***																		
4.1.A	Review with DDD preliminary data, stakeholder engagement themes, and literature review findings and then continue the assessment and discuss ways to establish and refine recommendations into the Final Report																		
4.1.B	Collect additional data based upon the review with DDD																		
4.2.C	Collaborate with DDD to outline and structure the Final Report																		
4.1.D	Compile comprehensive information and research collected throughout the entire project period																		
4.1.E	Finalize the comprehensive report																		
4.1.F	Conduct an overview meeting with DDD to discuss findings of the final report																		
4.1.G	Provide support to enable DDD to effectively communicate findings, recommendations, and next steps																		

2.E. Deliverables and Due Dates

1. *Conduct research through various methods, to include but not limited to, data analysis, stakeholder interviews, comparison of other states' methodology, to determine the reasons why participants remain in 24-hour group home settings versus living independently with less staff support.*

   Guidehouse acknowledges this deliverable and commits to providing this function throughout the term of the contract, as we consider this an ongoing function and deliverable based on various factors such as the current environment, any public health emergencies, lessons learned, etc.

2. *Provide steps for the Division to take in order to begin to help teams and providers move towards less restrictive residential settings for participants, including any incentives for providers. Meet with the division's leadership throughout the process in person or virtually, as requested.*

   Guidehouse acknowledges this deliverable and commits to providing this function throughout the term of the contract as we consider this an ongoing function and deliverable based on various factors such as the current environment, any public health emergencies, lessons learned, etc.

   We also commit to meeting with DHHS throughout the process in person or virtually as requested throughout out the term of the contract.

3. *Complete a draft report within nine (9) months of contract start, and review findings and suggestions with division leadership prior to completing final report.*

   Presuming an August 1, 2023, start date, Guidehouse will provide to DHHS a complete draft report **no later than May 31, 2024.** Regardless of the actual start date, Guidehouse will provide this deliverable within nine (9) months from contract start date.

4. *Complete a final report to include all items in the scope of work and submit to division leadership within eighteen (18) months of contract start.*

   Presuming an August 1, 2023, start date, Guidehouse will provide to DHHS a final report **no later than January 31, 2025**. Though DHHS allows this report to be delivered within eighteen (18) months, Guidehouse will provide this deliverable within seventeen (17) months from contract start date. This will allow Guidehouse time to conduct an overview meeting with DHHS to discuss the report's findings as well as provide support to enable DHHS to effectively communicate findings, recommendations, and next steps necessary to reduce reliance on congregate care. Regardless of the actual start date, Guidehouse will provide this deliverable within seventeen (17) months from contract start date.

Appendix A Guidehouse Staff Biographies and References

Tamyra Porter

Partner

tporter@guidehouse.com
Washington, DC
Direct: 202.973.3138

Professional Summary

Tamyra has more than 20 years of experience working in all aspects of Medicaid program design and implementation. Tamyra supports clients in the full life-cycle of program design including waiver support, stakeholder engagement, procurement, and contract development as well as robust development of organizational redesign supported by training and resource development for program oversight, monitoring, and quality improvement. Tamyra has deep expertise in special populations, long-term care, social determinants of health, and managed care. She has worked directly in:

Areas of Expertise

- Assists states with addressing reform and innovation to better manage long-term care programs including stakeholder engagements, development of quality measures, waiver redesign, improved care management, person-centered planning, uniform assessments, critical incident management, participant-directed programs, and provider rate and cost analyses.
- Assists states with evaluating program design and waiver options to better manage their Medicaid programs including waiver development, procurement and contracting, and developing internal infrastructure to monitor and drive quality improvements. Waiver experience with 1115, 1915b, 1915c as well as State Plan services. Has assisted states in exploration of new model options including Medicaid ACO, provider-sponsored health plans, health homes, etc.
- Works to address non-clinical needs and social determinants of health as part of improved consumer incentives, care management and overall population health improvement, including work in community development and housing as a means of improving health outcomes.
- Supports a variety of project teams at the intersection of federally regulated programs administered at the state and local level. In the public health arena, works closely on various data modernization and interoperability programs.
- Develops and manages various readiness assessment and oversight tools for Medicaid managed care oversight and compliance.
- Develops and deploys solutions to improve the use of Health Information Technology and data analytics assisting states in their goals for transparency and accountability through dashboards and other technology solutions.

Professional Experience

Long Term Care

- Provides a variety of supports to clients in the design and improvement of their long-term care programs. Projects she's led include in-depth program evaluation, implementation of

strategies to enhance and improve program administration and delivery including review of various state plan initiatives and 1915c waiver programs.

- Oversees a variety of projects to improved service definitions and reimbursement rates for HCBS programs and services, and overtime improved waiver oversight.

Medicaid Managed Care

- Ms. Porter has been involved in every aspect of the managed care life cycle from program concept and waiver development (1115 and 1915b waivers and other related programs) to supporting states in the development of procurement tools, evaluations and readiness of selected vendors.
- Provides ongoing resources for oversight and performance improvements related to managed care programs including training, workflow automation, dashboard reporting, etc.
- Provides specific expertise in a variety of key operational areas including network adequacy, quality and care management, technology support and compliance, financial performance, provider contracting, etc.
- Supports Medicaid Managed care clients in improving their performance in states.

Public Health and Program Innovation

- Support clients such as ASTHO in key program evaluations and technical assistance looking at programs including the CDC's Disabilities Champions and other projects from the Office of the National Coordinator to improve interoperability between immunization information systems and Health Information Exchanges.
- Assist clients in improved performance and oversight of their Ryan White services and programs.
- Manage and oversee projects related to evaluation of healthcare spending trends and related impact on state budgets and review of federal claiming and reporting through states' CMS 64 process. As a result of these projects, we have helped many of our clients recognize millions in savings.
- Provide oversight of various provider supplemental payment programs and compliance. Where some programs include technical assistance, have also created technical assistance models to support providers in achieving program goals affiliated with the receipt of these payments. For some of our rural hospital efforts, have led teams in transformative performance improvement.

Work History

- Manager, Tucker Alan Inc. (1999 – 2004)
- Web Developer, Assistant to the Chair of Obstetrics and Gynecology, University of North Carolina Hospitals (1998 – 1999)

Education

- Bachelor of Science in Public Health, Health Policy and Administration with Highest Honors, University of North Carolina at Chapel Hill, School of Public Health

Thought Leadership

- "Restructuring and Rethinking Public Health Agencies and Services" (Panelists 2023)
- "SDoH from Concept to Concrete" ACAP (2019)
- "Quality Measures and Outcomes" HSFO (2019)

- "Value-based Purchasing" HSFO (2019)
- "Value-based Payments for LTSS" NASUAD (2019)
- "Exploring the Intersection of Health and Housing" NASUAD (2019)
- Now is the time for Payvider Adoption and Growth" (2021)
- ASTHO -TechXpo, speaker/panelist (2021)
- "Spotlight on Behavioral Health: A Call for States to Meet Current Needs and Prepare for Post-Pandemic Surges" (November 2020)
- "State-based trends in leveraging telehealth post Covid-19" (2020)
- "Seven timely ways for states to use MFP funds" (2020)
- "Designing Comprehensive Contact Tracing Tools" Wellsky (2020)
- "State Budgeting During a Pandemic" Wellsky (2020)
- "Performance-based Contracting" HSFO (2019)
- "The Use of SDoH in Risk-based Rates" WHCC (2019)
- "Policy Options and Considerations for Sustainable Communities" Forum for Lt. Governors (2019)
- "Community Integration and Accountability" Congressional Leadership Meeting (2018)
- "Community Integration Workshop" WHCC (2018)
- "Innovative Approaches to Measuring Outcomes for HCBS Participants" NASUAD (2016)
- "Moving the Outcomes Needle – Integrating the Dually Eligible" NASUAD (2016)
- "Improving Your Purchasing Power – Procurement Opportunities" HSFO (2016)
- "Monitoring the Shift to Managed Care. Why is Monitoring Important?" World Congress Medicaid Managed Care Summit Presentation (2012)
- Readiness Review Trainings – Commonwealth of Pennsylvania Bureau of Managed Care Operations (Spring 2012)
- Monitoring Boot Camp - Commonwealth of Pennsylvania Bureau of Managed Care Operations (Fall 2012)

References

Tamyra Porter

Sandra Puebla, MSW	**Bryan Lumbra**	**Brian Campbell**
Deputy State Medicaid Director	*Rate Reform Analyst / Project Manager* State of Maine DHHS – Rate Setting Unit	*Senior Advisor* Complex Care and Services Commonwealth of Virginia Department of Medical Assistance Services
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Mark A. Thomas

Director

markthomas@guidehouse.com
Plaquemine, Louisiana
Direct: 225.802.4270

Professional Summary

Mark is an accomplished C-Suite healthcare executive with demonstrated local, state, and national organizational and operational leadership experience in private non-profit and public sector service delivery, management, and oversight. LTSS / Medicaid subject matter expert in the following areas Medicaid HCBS Waitlist Elimination / Reduction, Public Institution Downsizing / Rebalancing, Waiver Resource Allocation, Tiered Waiver Development / Implementation, Department of Justice Settlement Agreement for IDD, and Behavioral Health, HBCS settings Compliance, HCBS / LTMSS Integration, CMS relations, COVID-19 response for public and vulnerable populations.

Mark has performed operational and programmatic oversight of the statewide Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, Office of Behavioral Health, Office of Public Health, Five State Operated Facilities, and Statewide Human Service Interagency Council (Regional Operations).

He served as the Governor Appointee for nine years under Republican and Democratic Governors and served as Board President of the National Association of State Developmental Disability Directors.

Professional Experience

Director

- Focused on developing innovative solutions to national challenges at the intersection of Medicaid, aging, developmental disabilities, and public health
- Supported state government leaders to successfully implement healthcare programs that meet the needs of consumers and comply with all local, state, and federal programmatic and policy guidelines

Deputy Secretary / Chief Operating Officer

- Served as the spokesperson for the department in the absence of the Secretary and was the coordinator for LDH's Human Services Interagency Council ("HSIC") statewide regional operations
- Responsible for direct supervision over the Office of Public Health (OPH), Office of Behavioral Health ("OBH"), Office of Aging and Adult Services ("OAAS"), Office for Citizens with Developmental Disabilities ("OCDD"), and five publicly operated state facilities
- Supported the management of an operating budget of $18 billion and an overall table of organization of approximately 7,000 staff
- Provided oversight for all programmatic, budget, legislative, audit, policy, and operational responsibilities of all department program offices, facilities, and regions of the state Department of Health, serving more than 1.3 million Louisiana citizens annually

- Direct oversight of the Office of Public for $1 billion COVID-19 response and emergency preparedness activities since the beginning of the pandemic

Assistant Secretary, Office for Citizens with Developmental Disabilities

- Directed all programmatic components of the state Intellectual / Developmental Disability ("I/DD") system and directed budget oversight of approximately $143 million and an overall table of organization of 1,351 authorized positions
- Oversaw the management of approximately $1 billion dollars in community and waiver services and ICF / DD facilities, as well as the development and implementation of early steps and Medicaid community-based waiver programs and all support coordination functions which involves 10 local governing entities, including contracts with other health care, social services, and legal systems / agencies
- Directed all activities relative to all programmatic services operated through the Office for Citizens with Developmental Disabilities, including the establishment, and monitoring of policies and procedures associated with these operations

Deputy Assistant Secretary

- Directed the work activities of the OCDD Central Office and all programs in the absence of the Assistant Secretary and served as the Principal Assistant to the Assistant Secretary
- Directly supervised 11 staff persons including the OCDD Clinical Director, Executive Director of Waiver Services, Early Step Director, and all OCDD Regional Administrators
- Successful operational implementation of the Resource Allocation model across OCDD Central Office and statewide Regional Offices, Support Coordinators, and Providers. Average savings to date are $14,000-$1,000 per person. CMS consultant advised of a 3-year implementation timeline and the OCDD clinical staff achieved this task in a year and a half

OCDD Executive Director

- Responsible for oversight, management, and direction of Community Services for the OCDD, including statewide operational management for the delivery of over $650 million in services and supervision of more than 300 professional-level regional and state office staff. Program areas included Medicaid waivers, early steps, support coordination, provider relations, and state general fund programs

Executive Director / Chief Executive Officer

- Provided executive direction for all functions of this private non-profit United Way agency
- Fiscally and programmatically responsible for $4 million in services for persons with disabilities, mental illness, and the elderly
- Provided direct and indirect supervision to a staff of more than 200 employees

Work History

- Deputy Secretary, Chief Operating Officer, Louisiana Department of Health (2018 –2022)
- Assistant Secretary, Office for Citizens with Developmental Disabilities, Louisiana Department of Health and Hospitals (2013 – 2018)

- Deputy Assistant Secretary 3, Office for Citizens with Developmental Disabilities, Louisiana Department of Health and Hospitals (2009 – 2013)
- OCDD Executive Director, Community Services, Office for Citizens with Developmental Disabilities, Louisiana Department of Health and Hospitals (2006 – 2009)
- Executive Director, Chief Executive Officer, Community Opportunities of East Ascension (2001 – 2006)

Certifications, Memberships, and Awards

- 2017 Bernard R. Wagner Outstanding Leadership Award-Presented by the American Association on Intellectual and Developmental Disabilities for signification leadership and contributions to the field of intellectual and developmental disabilities
- 2017 Public Servant of the Year-Gold Award- Present by the Governor's Office of Disability Affairs
- Arc of Louisiana-Outstanding Communicator Award, Membership Award
- Mayor-President City of Baton Rouge-Certificate of Appreciation

Education

- Bachelor of Arts, Psychology, Louisiana State University
- National Conference of Executives-Leadership Academy Graduate-Fellow, Ascension Leadership Academy

References

Mark Thomas

Claudia Johnson	**Julie Foster Hagan**	**Mary P. Sowers**
Director	*Assistant Secretary*	*Executive Director*
Department of Behavioral Health Division of Developmental and Intellectual Disabilities	Louisiana Department of Health Office for Citizens with Developmental Disabilities	National Association of State Directors of Developmental Disabilities Services (NASDDDS)
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Amy R. Riedesel, MPA

Associate Director

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Professional Summary

As a consummate leader in the work of long-term services and supports across populations, Amy has more than 18 years' experience building and leading successful community-based programs. Her work is founded in person-centered philosophy and true community inclusion for people with intellectual or developmental disabilities and aging and disability populations. She has been a state-level leader of transformational change of health and social programs.

Amy has a keen ability to lead change through collaboration across partners. She can take complex issues and break them down in digestible ways to build efforts to work toward a common goal across internal and external partners, advocates, and stakeholders. She is committed to work to improve systems to recognize, respond to and meet individual needs, and engage partners to find common ground to make it happen.

Areas of Expertise

- Develops community-based case management models focused in person-centered philosophy
- Designs Medicaid 1915 (c) waiver models to include CMS applications, policy development, compliance and quality measurement metrics and monitoring
- Develops person-centered options counseling training and certification models for state implementation
- Leads Implementation of statewide competitive integrative employment models for people with Intellectual and Developmental Disabilities (IDD) to include technical assistance across network partners to transform programs
- Administration of participant-directed, or self-directed Medicaid Waiver services
- Manage implementation of case management software system build to include collaboration with IT software developers and state government staff to develop business requirements to meet the needs of statewide data collection
- Influence the adoption of No Wrong Door philosophy for access to community services
- Transformed Family Support Services for people with IDD to support family needs in the community for people with IDD to include collection of end-user feedback, provider contracts, claims system implementation, and policy help with stakeholder engagement across populations and users

Professional Experience

IDD

- Served as State Director of Community Services for people with IDD. Oversight included policy development, technical assistance and training, contract management, stakeholder engagement, budgeting, Managed programs including:

- Case management / Intensive case management
- Participant-Directed / Self-Directed waiver services for 3200 participants to include virtual training development and implementation for PD Representatives and people with IDD, e-newsletter and memo to improve communication, partnership with Office of Inspector General for fraud investigations, technical assistance, management of fiscal intermediaries associated with PD
- Supported employment- to include implementation of competitive integrated employment and Memorandum of Understanding with Vocational Rehabilitation Services to create seamless supports. Appointed to State Employment First Advisory Council
- Family Support Services / Intensive Family Support Services
- Statewide IDD Case Management data collection system implementation
- Aging and disability resource connection liaison
- 1915 (c) waiver renewal for IDD to include additional of assistive technology as a service option
- State-funded respite services
- Appendix K for Public Health Emergency

Aging

- Serviced as the Aging and Disability Resource Connection manager for the state aging authority
  - Developed and implemented statewide training and certification for Minimum Data Set Section Q and Community Options Counselors grounded in person-centered philosophy
  - Led development of strategic plan and implementation of person-centered transformation of aging services
  - Influenced the addition of Assistive Technology Access in Area Agencies on Aging to promote use of Assistive Technology to assist in people aging in place
  - Managed the Money Follows the Person initiative for skilled nursing facilities transition to community living across aging and disability populations
  - Oversight of statewide conference planning to include engagement of aging and disability partners in No Wrong Door approach to access to care

Population Health

- Managed Center for Disease Control and Prevention, Population Health grant on population health with focus on diabetes, high blood pressure, and chronic disease impact on health within a rural health system
- Implemented evidence-based health and prevention programs
- Led partnership with local university for social determinants of health internship for all RN students
- Collaborated with community organizations and stakeholders to implement a population health awareness campaign
- Directed the implementation of data tracking system to evaluate population health outcomes

- Evaluated impact of preventative health programs through African-American Faith-based initiatives, school-based nutrition and physician referral programs

Work History

- Associate Director of Healthcare, Guidehouse (2021-Present)
- State Director of Community Services, Georgia Department of Behavioral Health and Developmental Disabilities (2018 – 2021)
- Director of Community Health, Tanner Health System (2015 – 2017)
- Statewide Manager Aging and Disability Resource Connection, Department of Human Services, Division of Aging Services (2011 – 2015)
- Program Manager, Three Rivers Area Agency on Aging (2007 – 2011)
- Case Manager, Communities in Schools, LLC (2006 – 2007)
- Behavioral Health Technician, Passages Day Treatment Center (2003 – 2005)
- Program Manager, National Multiple Sclerosis Society (2002 – 2004)
- Medic United States Army and US Army Reserves (1996 – 2003)

Education

- Master of Science Public Administration, Health Policy Emphasis (Summa Cum Laude), University of West Georgia
- Bachelor of Science, Human Development (Cum Laude), State University of New York at Binghamton
- Associate in Applied Science Medical Laboratory Technology, SUNY Broome Community College, NY
- Graduate Certificate in Aging, Boston University
- Citizen-centered Leadership, Cornell University

References

Amy Riedesel

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Jayson Wright

Managing Counsultant

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Professional Summary

Jayson (Jay) has nearly 15 years of experience working with state Health and Human Services agencies supporting Long-term Services and Supports (LTSS) through a wide variety of projects and programs. His is passionate about improving the lives of the aging and disability populations by enhancing the services and support systems that allow these individuals lead independent lives.

Jay specializes in creating programs and systems to address new challenges or take advantage of new opportunities. He has supported the development and implementation of nursing home transition programs, Community Health Hubs that bridge clinical and home- and community-based services, and as of 2023: Multisector Plans on Aging.

Areas of Expertise

Jay has experience with 1915(c) waivers with state Medicaid agencies, Medicaid providers, non-profits, and communities. His expertise includes: **Money Follows the Person (MFP) and Rebalancing efforts**, Georgia's non-Medicaid Nursing Home Transition (NHT) program, and multi-program collaborations with Centers for Independent Living (CIL). In addition, he has developed and managed state-funded Division of Aging Services-specific policy.

- Multisector Plans on Aging
- 1915(c) waivers
- American Rescue Plan Act, Section 9817 Spending Plans
- Aging population policies and programs
- Data system implementation to support social service program quality and reporting

Professional Experience

Guidehouse

- Develop and implement American Rescue Plan Act (ARPA), Section 9817 HCBS Spending Plans
  - Supported the design of spending plan initiatives for multiple states
  - Supported the implementation of spending plan initiatives
- Assist to develop community health hub concept for aging services providers
- Conduct rate reviews for HCBS 1915(c) waivers for CMS compliance
- Redesign Participant Directed Services (PDS) for 1915(c) waivers
  - Develop policy, procedure, and standards of operation for PDS services

  - Assist with development of a self-assessment tool to support education of new PDS service model participants
  - Support stakeholder engagement in redesign efforts
- Support development of non-traditional encounter payment policy for managed long-term services and supports
- Evaluate provider contracts to support contract management database migration

Georgia Department of Community Health, State Medicaid Agency

- Support Sustainability Plan efforts to permanently integrate MFP Grant processes into Georgia 1915(c) Medicaid Waivers
- Write policy, procedure, and key elements of waiver renewal / amendments
- Develop and maintain project plan to ensure key milestones are met by deadline
- Involve internal and external stakeholders and incorporate feedback
- Lead Transition Coordination Certification development and implementation

Georgia Department of Human Services

- Manage the MFP program for 12 Area Agency on Aging service regions
- Develop housing, assistive technology, and transportation initiatives
- Train, monitor, and provide technical assistance to 20-25 transition coordinators statewide
- Collaborate with state agencies, Medicaid providers, non-profits, and communities to support transitions
- Develop and manage state-funded Division of Aging Services (DAS) NHT program through 12 service regions and nine CILs
- Core team member in two-year implementation of DAS data system
  - Supported migration of program data from static documents (such as PDF and Excel files)
  - Assisted with configuration of data entry screens
- Developed, wrote, and implemented DAS-specific policy for MFP and NHT
  - Updated master contracts to include MFP and NHT reimbursement and reporting requirements
- Provide continuous training to transition coordinators and related staff

Work History

- Business Operations Manager, Georgia Dept. of Community Health (2017 – 2019)
- MFP Program Coordinator, Georgia Dept. of Human Services (2011 – 2017)
- MFP Transition Coordinator, B&B Care Services (2009 – 2011)
- Marketing Director, Mi Casa Care, Inc. (2008 – 2009)
- Account Manager, MC-2 (2006 – 2008)

Education

- Bachelor of Arts in Journalism and Advertising, Minor in Theatrical Arts, University of Georgia

Thought Leadership

- Co-Author, Delivering Telehealth to Home and Community-Based Services: Strategies to Drive Service Effectiveness While Responding to COVID-19, Guidehouse.com

References

Jayson Wright

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Appendix B Request for Proposal for Contractual Services Form

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal and agrees to the terms and conditions unless otherwise indicated in writing, certifies that contractor maintains a drug free workplace, and certifies that bidder is not owned by the Chinese Communist Party.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

____ a Nebraska Contra de place of busine ly preceding the po

Not Applicable

___ I d enterprise zone i , considered in the

____ d & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

BIDDER:	Guidehouse Inc.
COMPLETE ADDRESS:	Tysons Corner – Global Headquarters 1676 International Drive, Suite 800 McLean, Virginia 22102
TELEPHONE NUMBER:	571.633.1711
FAX NUMBER:	312.276.8658
DATE:	June 14, 2023
SIGNATURE:	Tamyra Porter Digitally signed by Tamyra Porter Date: 2023.06.12 13:30:41 -05'00'
TYPED NAME & TITLE OF SIGNER:	Tamyra Porter, Partner

Appendix C Guidehouse Sample Reports

Alabama Medicaid Agency
Medicaid

ALABAMA'S INTEGRATED CARE NETWORK (ICN) PROGRAM

CONCEPT PAPER MARCH 2018

TABLE OF CONTENTS

SECTION I EXECUTIVE SUMMARY

Over the last few years, the Alabama Medicaid Agency has been working closely with the Centers for Medicare and Medicaid Services (CMS) to develop a long-term care program that is sustainable under the state budget and that allows the State to strengthen its current programs, offering more community options. Following conversations with CMS, the Agency identified the Primary Care Case Management (PCCM) Entity approach as a feasible strategy to pursue the goals of the program.[1]

If this approach is approved by CMS, the Agency will contract with an Integrated Care Network (ICN) to support the PCCM Entity model. The ICN will complement and enhance the current long-term services and supports (LTSS) system by introducing tools to better manage the medical and LTSS needs of beneficiaries, educating beneficiaries and other stakeholders about the full array of LTSS options, and working with participants to promote LTSS use in the least restrictive setting. With the ICN program, the State will implement a system with managed care components, including a strong emphasis on case management, outreach, and adjusting the LTSS balance of institutional versus home and community based services (HCBS) utilization.

The ICN will receive a per member, per month payment that will cover the enhanced case management, education, and outreach activities that are not delivered currently. The per member, per month payment will also cover HCBS case management activities. The ICN will be required to contract with local Area Agencies on Aging (AAAs) to deliver HCBS case management services for the first two years of the program, and the ICN must reimburse the AAAs for HCBS case management services at a minimum rate equal to the prevailing Medicaid fee-for-service payment schedule, unless otherwise jointly agreed to by a AAA and the ICN. The ICN will be held accountable for increasing the percentage of members living in HCBS settings compared to a baseline.

The ICN program will serve individuals who reside in a nursing facility long-term and individuals who receive HCBS waiver services through the Elderly and Disabled and Alabama Community Transition (ACT) waivers; however, the following populations will not be enrolled into the ICN program:

- State of Alabama Independent Living (SAIL) waiver participants
- Technology Assisted (TA) waiver participants
- Participants in either of the two waivers serving individuals with intellectual and developmental disabilities (I/DD)
- Individuals in Alabama's Program for All Inclusive Care for the Elderly (PACE)

[1] PCCM entities, defined in *42 CFR 438.2*, are organizations that provide primary case management services – which include the location, coordination, and monitoring of primary health services – as well as additional functions, such as provision of telephonic or face-to-face case management and development of enrollee care plans.

- Individuals living in an intermediate care facility
- Individuals receiving Medicaid funded hospice room and board in a nursing facility, or Medicaid funded hospice in the community

The Agency will conduct a competitive procurement process with the intention of selecting a single ICN. The ICN must demonstrate it can meet all Federal and State ICN requirements via a readiness review that will be conducted prior to the program implementation date. The ICN program is planned to begin on October 1, 2018.

The purpose of this concept paper is to inform the public about the design and implementation of the ICN program. It incorporates themes and input from public comments received to date as well as background on LTSS in Alabama. It also introduces proposed ICN program design and implementation concepts. Specifically, this concept paper addresses the following:

- ICN program goals
- Proposed ICN structure
- ICN program eligibility
- Education and outreach services
- Case management services
- Services retained by the Medicaid Agency
- Payment approach
- Quality measurement

SECTION II BACKGROUND

Current LTSS System

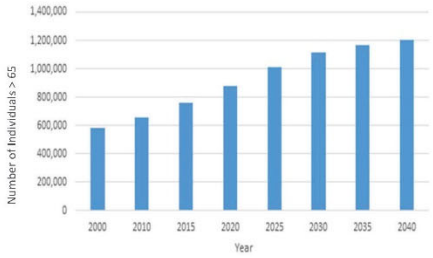
The Alabama LTSS system provides institutional care and HCBS to more than 23,000 elderly and disabled adults who meet the Medicaid financial eligibility requirements for long-term care and demonstrate need qualifying the individual for nursing facility level of care, as defined by the Agency.[2] More than 200 nursing facilities provide nursing facility care to more than 23,000 Medicaid beneficiaries each year. There is an average of 16,000 individuals in a nursing facility on any given day across the State. HCBS are available statewide through HCBS waivers. As of 2016, there were 10,030 waiver slots across the two waiver programs intended for inclusion in the ICN program.

[2] Alabama Medicaid Administrative Code Rule 560-X-10-.10.

Beneficiaries covered by waivers for persons with I/DD and the SAIL or TA waiver programs will not be included in the ICN program; those waivers will continue to be administered on a fee-for-service basis by the State.

The Agency is also considering ways to strengthen the LTSS system in advance of the anticipated influx of aging Alabamians. As illustrated in Figure 1 below, trends suggest that the aging adult population in Alabama will double between the years 2000 and 2040. Although not all aging adults qualify for Medicaid or require Medicaid-funded LTSS, there is anticipated growth in need for these services, as adults live longer and as the family caregiving structure changes over time.

Figure 1. Growth of the Aging Population in Alabama

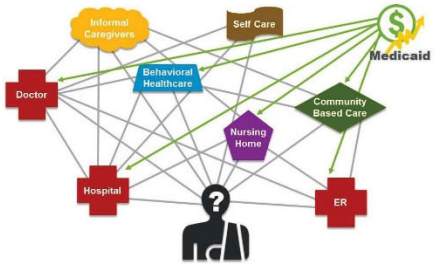


Note: Analysis of population calculated using the following source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, March 2015

There is opportunity for the State to reposition its LTSS delivery system to serve more individuals who are aged and physically disabled within HCBS settings. This shift poses several benefits, such as meeting the demand of adults who prefer to receive care in a community-based setting, preventing avoidable institutional LTSS delivery, and achieving cost savings associated with increased HCBS.

Like many states, Alabama's current LTSS service delivery system is fragmented. As illustrated in Figure 2 below, beneficiaries and their families are often left to navigate the complex web of healthcare services and providers by themselves. Stakeholders across the State have expressed a need for increased coordination across the care continuum.

Figure 2. Fragmentation in the LTSS Delivery System



Stakeholders have also expressed a lack of knowledge about HCBS options and often are not aware of LTSS services until they have an immediate need; frequently, this need is related to acute care. Individuals who inquire with their physicians about LTSS have reported that their primary care doctor typically deferred to nursing facility care and did not provide information on community-based alternatives. Many beneficiaries currently receiving Medicaid LTSS use acute care and emergency rooms to obtain urgent care or medical attention needed outside of standard business hours, including for chronic disease management, and have struggled with self-management of medications. Furthermore, stakeholders report that accessing mental health services is a challenge for many in the LTSS population, particularly for those who are homebound. The ICN will be tasked with identifying opportunities to improve LTSS education, awareness of HCBS services, and improved linkage to healthcare services throughout the State.

SECTION III PROGRAM DESIGN

A. ICN PROGRAM GOALS

With the implementation of the ICN program, the Agency intends to create a more sustainable infrastructure for the delivery of Medicaid-funded LTSS in Alabama. The Agency seeks to promote a person-centered approach to care delivery that includes better management of the medical and LTSS needs of beneficiaries, allowing them to receive LTSS in the least restrictive setting of their choice. The ICN will implement innovative approaches to:

- Improve education and outreach about LTSS options
- Provide more comprehensive and integrative case management that drives person-centered planning, enhances quality of life, and improves health outcomes
- Help drive a shift in the percentage of the LTSS population residing in the HCBS setting

B. PROPOSED ICN STRUCTURE

The ICN must have a governing board of directors. A portion of the governing board members must be risk-bearing participants in the ICN, a subset of which must be long-term health care providers or representatives of long-term health care providers. The ICN may be a for-profit or non-profit entity and will be required to operate statewide. The ICN must demonstrate it can meet all Federal and State requirements by completing a readiness assessment to the satisfaction of the Agency.

The ICN will be required to contract with the statewide network of AAAs for HCBS waiver case management services. The ICN will also be required to have coordinating agreements with nursing facilities to share information and recommend medical interventions for ICN enrollees residing in nursing facilities, supplementing the responsibilities of nursing facility case management staff.

C. BENEFICIARY ELIGIBILITY FOR THE ICN PROGRAM

Individuals must be Medicaid eligible and must meet the nursing facility level of care to enroll in the ICN program. The nursing facility level of care is defined by Alabama Medicaid Administrative Code Rule 560-X-10-.10 and includes a number of skilled nursing care services required by beneficiaries, in addition to any functional impairment of Activities of Daily Living (ADLs) such as transfer, mobility, eating, and toileting, or intermediate Activities of Daily Living (IADLs) such as medication administration.

Individuals who meet the Agency's financial eligibility criteria and who are determined by a physician to meet the defined level of care to qualify for a nursing facility will be eligible to participate in the ICN program if they also fall into one of the following groups:

- **Medicaid beneficiaries receiving care within a nursing facility**. Medicaid beneficiaries who currently receive custodial, long-term care within a nursing facility will be included in the ICN program.[3]
- **Medicaid beneficiaries receiving care through select HCBS waiver programs.** The Agency plans to include Medicaid beneficiaries currently enrolled in the following HCBS waiver programs in the ICN program (See Appendix A for additional waiver program information):
  - *Elderly and Disabled Waiver* – targeting individuals who are frail or physically disabled.
  - *Alabama Community Transition (ACT) Waiver* – targeting individuals currently residing in institutional long-term care who seek to transition to an HCBS setting.

Individuals who are dually eligible for Medicaid and Medicare will be included in the ICN program if they live in a nursing facility or are enrolled in one of the two HCBS waivers mentioned above. Dual eligibles will comprise a large portion of ICN enrollment—currently, more than 85 percent of Medicaid beneficiaries receiving LTSS are dually eligible for Medicare. The ICN will be expected to coordinate with Medicare, including Medicare Advantage and Medicare Special Needs Plans, and other health plans as necessary to drive coordinated and effective patient care.

It is important to note that dually eligible individuals will retain choice for their Medicare coverage. The ICN program will not impact Medicare enrollment, and ICN members will continue to follow Medicare eligibility timeframes and procedures for selecting or switching their Medicare plan.

The following individuals who meet the nursing facility level of care will ***not be eligible for*** the ICN program:

- Individuals enrolled in the SAIL waiver
- Individuals enrolled in the TA waiver
- Individuals enrolled in the Intellectual Disabilities waiver
- Individuals enrolled in the Living at Home Waiver

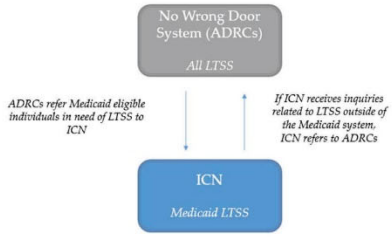
[3] Custodial care is nonmedical assistance with the activities of daily living (such as bathing, eating, dressing, or toileting) provided at home, in a nursing facility, or an assisted-living facility for someone who is unable to fully perform those activities without help.

- Individuals receiving Medicaid funded hospice room and board in a nursing facility, or Medicaid funded hospice in the community
- Individuals living in an intermediate care facility for individuals with intellectual disabilities
- Individuals enrolled in the PACE program[4]

D. EDUCATION AND OUTREACH SERVICES

The ICN will serve as the primary source of contact for Medicaid LTSS and will be responsible for providing education and outreach about LTSS options to Medicaid eligible beneficiaries. While Aging and Disability Resource Centers (ADRCs) will continue to serve as the LTSS entry point for all individuals seeking information and assistance with the LTSS system, the ADRCs will refer Medicaid eligible individuals in need of LTSS to the ICN for further education about LTSS settings and available options.

Figure 3. ICN as the Primary Source of Contact for Medicaid LTSS



The ICN will educate Medicaid eligibles about nursing facility and HCBS waiver options and help direct them to the most appropriate placement of their choice. By working with these individuals as they enter the LTSS system, the goal is to impact the percentage of LTSS individuals receiving community-based services.

Similarly, the ICN will coordinate with and provide hospitals with educational resources on community options. For example, the ICN will educate hospital discharge planners regarding placement options for Medicaid eligibles who are expected to need a nursing facility level of care

[4] PACE is currently only available through Medicaid in Mobile and Baldwin counties.

long-term. In 2009, 27.2 percent of the elderly population (65 and older) that were hospitalized from communities were discharged to a nursing facility.[5] Because a sizable percentage of older adults go to nursing facilities after an acute hospital stay, it is important to include hospitals in discussions about HCBS placements. The ICN will also develop relationships with other community organizations that interact with the LTSS system to promote awareness of the ICN's services.

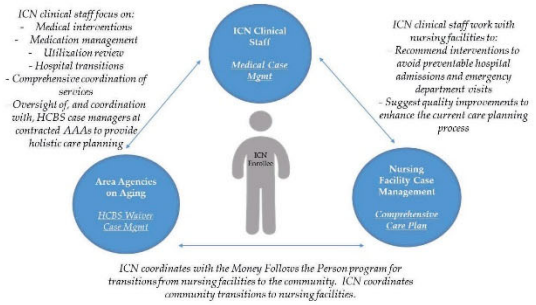
E. CASE MANAGEMENT SERVICES

Today, case management services for Medicaid beneficiaries needing LTSS are limited to case management provided to HCBS waiver participants, which primarily coordinates waiver services and other community benefits, but offers little integration with clinical and other Medicaid-funded services. Waiver case management is currently provided through AAAs operating through regional commissions, county-based agencies, or local non-profits.

Under the ICN program, ICN clinical staff will coordinate all services for members to support their overall health and well-being – not just their long-term care needs. The ICN will contract with the AAAs for HCBS case management activities for at least the first two years of the ICN program. The ICN must also develop the resources to deliver medical case management and linkages to healthcare services, including transitions to and from the hospital, nursing facilities, other care settings and the community; medication management; and utilization review. The ICN clinical staff will also oversee and coordinate with the HCBS case managers at contracted AAAs to provide holistic care planning. Together with the AAAs, a blend of nursing and social work professionals will provide medical and HCBS case management.

[5] Agency for Healthcare Research and Quality, "Transitions between Nursing Homes and Hospitals in the Elderly Population, 2009. September, 2012. Available Online: https://www.hcup-us.ahrq.gov /reports/statbriefs/sb141.pdf

Figure 4. ICN Oversees and Coordinates Case Management Services with AAAs and Nursing Facilities



The ICN clinical staff will also work with nursing facilities to recommend interventions to avoid preventable hospital admissions and emergency department visits and suggest quality improvements to enhance the current care planning process. The Agency will routinely review and approve the ICN's strategy and staffing plan for offering this level of support and will work with the ICN to continuously improve this process.

F. SERVICES RETAINED BY THE ALABAMA MEDICAID AGENCY

Although the ICN will be responsible for education, outreach, and case management services as described above, a number of services will be retained by the Agency. The Agency will continue to process claims and pay for all Medicaid-covered services on a fee-for-service basis, with the exception of HCBS case management services for the Elderly and Disabled and ACT waivers; however, the ICN will have an option to enter into an agreement with the Agency's Fiscal Agent to process HCBS case management claims on the ICN's behalf. There will not be any disruption in the delivery of Medicaid services to ICN enrollees. The Agency will also maintain responsibility for prior authorization of services.

The Agency will continue to be responsible for the Medicaid provider network, and ICN enrollees will continue to have their choice of any Medicaid fee-for-service provider. The ICN will be expected to coordinate with providers to support case management activities, but will not be charged with network development functions at this time. However, the ICN will be encouraged to alert the Agency to gaps in the HCBS service delivery network in an effort to promote HCBS availability across the State.

The Agency will also collect and process grievances regarding the ICN and the ICN program and will work collaboratively with the ICN to address and identify solutions to the grievances.

G. PAYMENT APPROACH

If approved by CMS, the ICN will receive a per member, per month payment that will cover the enhanced case management services and education and outreach activities not currently delivered today. The per member, per month payment will also cover HCBS case management activities. The ICN will be required to contract with local AAAs to deliver HCBS case management services for the first two years of the program, and the ICN must reimburse the AAAs for HCBS case management services at a minimum rate equal to the prevailing Medicaid fee-for-service payment schedule, unless otherwise jointly agreed to by a AAA and the ICN.

The ICN will be held accountable for increasing the percentage of members living in HCBS settings, compared to a baseline. The Agency will establish a target mix of nursing facility and HCBS enrollees annually. This target mix is assumed to have a lower percentage of nursing facility residents compared to the current mix of nursing facility residents, with a larger portion of the population in HCBS setting. The Agency will withhold a portion of the ICN's per member, per month payment, contingent on the ICN achieving this target mix. If the ICN increases the proportion of HCBS enrollment beyond the target mix, the ICN would be eligible for an incentive payment in addition to the withheld funds.

H. QUALITY MEASUREMENT

The Agency will continue to leverage the work of the ICN Quality Assurance Committee (QAC). The ICN QAC is responsible for identifying quality measures to monitor the quality and overall success of the ICN program. The ICN QAC consists of more than 20 members, representing diverse provider associations, advocacy groups, and state agencies.

On January 24, 2017, the ICN QAC selected quality measures that will be used to evaluate ICN performance. These measures will also complement the monitoring tasks that the Agency will conduct related to its waiver assurances and ICN contract requirements. Anticipated quality measures span eight different quality domains:

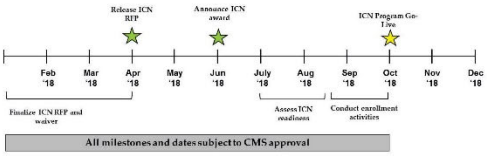
1) Clinical
2) Long-Term Care
3) Service Delivery and Effectiveness
4) Person-Centered Planning and Coordination
5) Choice and Control
6) Community Inclusion
7) Holistic Health and Functioning
8) System Performance and Accountability

The Agency will support the ICN in its quality management activities by providing quality measure reports to the ICN that the ICN will then use to inform quality improvement activities. As the ICN program develops, the ICN QAC will monitor the quality measures and make adjustments based on performance and program changes as necessary.

SECTION IV IMPLEMENTATION TIMELINE

The ICN program is planned to begin on October 1, 2018. The implementation timeline illustrated in Figure 5 will hinge on CMS's approval of both the 1915(b) and (c) waiver applications and amendments, and the Agency's readiness review determination.

Figure 5. ICN Implementation Timeline



The Agency plans to issue a Request for Proposals (RFP) for entities interested in serving as an ICN in early Spring 2018. The Agency will also submit a 1915(b) waiver application and 1915(c) waiver amendments to CMS in mid-2018 to receive approval to implement the ICN program.[6]

The Agency plans to conduct readiness reviews in mid-2018, during which the Agency will review the selected ICN to ensure that it has the necessary processes and resources in place to begin providing services by October 1, 2018. Readiness reviews will entail desk reviews of documents submitted by the ICN to the State and onsite reviews of ICN offices. Finally, enrollment activities will begin in August 2018, including member outreach, enrollment support, and transition assistance.

[6] As mentioned in Section III.C., the Agency plans to include two 1915(c) waivers in the ICN program: the Elderly and Disabled Waiver and the ACT, along with their designated waiver slots and associated funding.

SECTION V CONCLUSION

The ICN program will improve the way Alabama delivers Medicaid-funded LTSS by introducing more managed care elements, as the ICN will take on some financial risk and accountability for improving the HCBS mix. The ICN will receive a monthly payment to deliver case management, education, and outreach to eligible Medicaid beneficiaries. The overarching goal of the ICN program is to create a more sustainable infrastructure for the delivery of LTSS—one that better integrates the medical and long-term care needs of Alabama's most vulnerable Medicaid beneficiaries and one that gradually shifts LTSS service delivery and expenditures from nursing home care to HCBS.

APPENDIX A: CURRENT WAIVER PROGRAMS COVERED UNDER THE ICN PROGRAM

The figure below provides a brief description of the two Medicaid HCBS waivers that the Agency plans to include in the ICN program.

Figure 6. Waiver Program Descriptions

	Elderly and Disabled Waiver	Alabama Community Transition Waiver
Target Population	Individuals meeting the nursing facility level of care	Individuals with disabilities or long term illnesses currently residing in a nursing facility
Services Provided	• Case Management • Homemaker Services • Personal Care • Adult Day Health • Respite Care (Skilled and Unskilled) • Companion Services • Home Delivered Meals	• Case Management • Transitional Assistance • Personal Care • Homemaker Services • Adult Day Health • Home Delivered Meals • Respite Care (Skilled and Unskilled) • Skilled Nursing • Adult Companion Services • Home Modifications • Assistive Technology • Personal Emergency Response Systems • Medical Equipment Supplies and Appliances • Personal Assistant Services

Guidehouse
Outwit Complexity

New York State Office for People With Developmental Disabilities (OPWDD)
Managed Care Assessment Initial Report

December 28, 2022

guidehouse.com

Table of Contents

Section 1 Background and Assessment Methodology

As managed care has gained momentum as a service delivery model for particular segments of the Medicaid population, many states have explored the option of providing people with intellectual and developmental disabilities (IDD) Managed Long Term Services and Supports (MLTSS). MLTSS refers to the delivery of long-term services and supports through capitated Medicaid managed care programs (i.e., fixed monthly payments made to managed care organizations for each Medicaid member enrolled in the managed care organization). New York State and the Office for People With Developmental Disabilities (OPWDD) have been considering such a transition for a number of years including the implementation of smaller pilot programs such as Specialized IDD Plans – Provider Led (SIPs-PL) and the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plan demonstration. The IDD population includes many of New York's most vulnerable residents and a transition to MLTSS may result in a change to how they receive their services and how the State pays for those services. To that end, per Section 9, paragraph 1(b), of Part Z of Chapter 57 of the Laws of 2018, OPWDD must "assess the quality and outcomes of managed care for individuals with developmental disabilities, including their experiences and satisfaction"[1].

Guidehouse has been retained by OPWDD to evaluate service delivery models and is working in close coordination with OPWDD to draft this report.

Our assessment will include this Initial Report and a Final Report. Guidehouse's Initial Report includes:

- Summary of OPWDD goals and objectives
- Overview of current delivery system in New York including how managed care is used today
- Environmental scan and high-level overview of service delivery models, next steps, and timing of Final Report

Between 2023 and Spring 2024, Guidehouse will continue its work with OPWDD to produce a Final Report by completing the following steps that are detailed in Section 5 of this document:

- Environmental scan, literature review, and data analysis
- Best practices and national trends including how states are currently implementing managed care and other service delivery models
- Stakeholder engagement

The Final Report, to be submitted to OPWDD in Spring 2024, will include:

- **Service Delivery Model Study Methodology and Findings**: Comprehensive summary of the service delivery study methodology and findings focusing on managed care and other options currently implemented nationally.

[1] https://assembly.state.ny.us/leg/?default_fld=&bn=S07507&term=2017&Summary=Y&Actions=Y&Text=Y&Committee%2526nbspVotes=Y&Floor%2526nbspVotes=Y

- **OPWDD Program Goals:** Detailed perspective of OPWDD program goals, objectives, and measures of success to execute and monitor OPWDD's progress towards achieving goals based on the recommended service delivery system.
- **Final Recommendations:** Recommended next steps for selection and implementation of a service delivery model. This will include key program requirements of the recommended service delivery model to successfully serve the IDD population across New York.

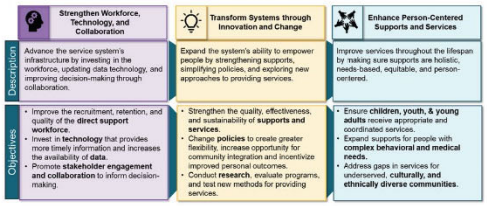
Section 2 OPWDD Service Goals and Objectives

OPWDD is responsible for coordinating supports for approximately 130,000 New Yorkers with intellectual and developmental disabilities, collaborating with nearly 500 voluntary non-profit organizations to provide ongoing support (housing and residential supports, community habilitation, day and employment programs, family support services, and respite). OPWDD services are focused on maximizing opportunities for those with developmental disabilities to live and participate in the broader community.

OPWDD has experienced an increase over the past five years in both the number of people served and the amount in Medicaid expenditures (over 14% over five years), totaling more than $8 billion of total system expenditures in 2021. In addition to the increase in spending and the expanding needs of the community, OPWDD has experienced a decline in available Direct Support Professionals (DSPs)[2] and has experienced a high turnover rate in voluntary DSP positions (averaging 36% annually) while contending with an increase in open position vacancy rates. Collectively, these issues have created challenges for OPWDD and its ability to provide quality and timely services to those in need. In addition to expanding needs and a shrinking available workforce, OPWDD has identified that its current systems and technology – critical to providing valuable insights – are outdated, hampering its ability to maximize impact for its members.[3]

OPWDD looks to address these changing dynamics and demographics with its five-year (2023-2027) Strategic Plan, establishing goals and objectives that will allow OPWDD to operate more effectively within the changing environment. The five-year plan was the result of engaging with, and gathering input from, stakeholders statewide and analyzing state and local data. The result was three strategic goals and associated objectives (Figure 1).[4]

Figure 1. OPWDD 2023-2027 Strategic Plan Goals and Objectives



[2] Direct Support Professionals (DSPs) provide assistance to people with all of their personal needs and help them participate in programs that strengthen their life skills and ensure a safe and comfortable environment.
[3] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf
[4] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf

To ensure OPWDD meets the changing needs of those served and improve their experience, OPWDD is:

- Strategically prioritizing the strengthening of New York's IDD workforce, technology, and cross-system collaborations (Goal 1)
- Evaluating and modifying its policies and services (Goal 2), as OPWDD believes this will serve as the foundation for transforming OPWDD systems
- Setting OPWDD up to achieve person-centered services (Goal 3).

As part of transforming its systems through innovation and change, OPWDD will conduct research, evaluate programs, and test new methods for providing services, including reviewing OPWDD's potential transition to managed care or an alternate delivery system. To continually provide the community with high quality, person centered, cost-effective services, OPWDD has invested in studying and exploring the effectiveness and sustainability of its current delivery model as well as alternative delivery models, including managed care, with the goal of implementing the best option for New Yorkers with developmental disabilities.

Section 3 New York State Service Delivery

OPWDD Populations

OPWDD is responsible for coordinating supports for approximately 130,000 people; providing benefits through a variety of service options.

Medicaid Only

Individuals who receive Medicaid exclusively

Duals

Individuals who receive both Medicare and Medicaid benefits

Private/Commercial

Individuals who receive services through private/commercial payers

Exemptions

Individuals who receive coverage through an exemption basis (e.g., Native Americans, individuals with end-stage renal disease)

History of Medicaid Managed Care in New York State

New York State has had a Medicaid managed care program for several decades, with the State's first programs beginning in the 1980s. In 1998, New York State launched its first Managed Care Program for Medicaid-eligible individuals using long-term services and supports (LTSS) in select counties, including adults with disabilities and dual eligibility. In 2006, New York State sought a waiver under Section 1115 of the Social Security Act to expand its Medicaid managed care enrollment and to institute mandatory enrollment into Medicaid managed care, which eventually resulted in the Managed Long-Term Care (MLTC) program. In 2011, New York launched a Medicaid Redesign Team (MRT) effort that included a number of initiatives to control spending and increase quality. One initiative called for mandatory enrollment into managed long-term care for dual-eligible individuals in need of more than 120 days of community-based long-term care. The MLTC program covers institutional and community-based long-term services and supports; acute and primary care services are provided by a different managed care program.

Since mandatory MLTC enrollment, the State's Medicaid managed care program has continued to expand by including new populations and creating specialized managed care programs for individuals with special needs, including those with physical disabilities, frail elders in need of long-term services and supports, and individuals with serious mental illness (SMI) and substance use disorders (SUD). As of November 2022, more than 5.9 million New Yorkers were enrolled in some form of Medicaid managed care. However, most people with IDD have largely been exempted (or "carved out") from Medicaid managed care.

Intellectual/Developmental Disabilities (IDD) Health Homes / Care Coordination Organizations

For several years, OPWDD and the New York State Department of Health (DOH) have considered the possible transition of OPWDD-funded waiver services to managed care. In April 2018, DOH and OPWDD received approval from the Centers for Medicare and Medicaid Services (CMS) to expand the Health Home Care Management program to serve people with IDD through Care Coordination Organizations/Health Homes (CCO/HHs). CCOs are organizations formed by providers of developmental disability services that were designed to provide enhanced care coordination through comprehensive person-centered care management, planning, and coordination through a network of care managers and providers (team-based approach). The care management process includes the development of a Life Plan, which represents an individual's goals and changing needs including health, preventive care, behavioral services, community supports, and social supports.

The intent of the CCO/HH model was to better integrate primary healthcare with Medicaid home and community-based services (HCBS) with more options, greater flexibility, and improved outcomes. Additionally, as part of compliance with the HCBS final rule, the transition provided the opportunity to achieve conflict-free case management, which assures that assessment and coordination of service needs are separate from delivery of those services. Today, despite a system-wide transition to managed care having not yet occurred, there are seven regional CCOs across the State responsible for assessing the needs of their enrollees and for providing conflict-free person-centered care management services.

Membership Service Array/Utilization

Each CCO has a designated care manager or professional who provides care management and coordinates services.

Health Homes currently provide six core care management services:

- **Comprehensive care management:** Initial and ongoing assessment and care management services – to support individual outcomes and integration of habilitation, primary, behavioral, and specialty healthcare and community support services, using a comprehensive person-centered care plan called a Life Plan.
- **Care coordination and health promotion:** Education and engagement in making decisions that promote independence and wellbeing through the implementation of the Life Plan and its continuous monitoring.
- **Comprehensive transitional care:** From inpatient to other settings, including appropriate follow-up.
- **Individual and family and caregiver support:** Coordination of information and services to support each individual and their family and/or representative to maintain quality of life, with a focus on community living options.
- **Referral to community and social support services:** To ensure that community resources are utilized, as individuals pursue meaningful activities consistent with their Life Plans

- **The use of health information technology (HIT):** CCOs are required to meet the HIT standards in the delivery of the Health Home core services. This includes an electronic Life Plan.

Enrollment Transition

In July 2018, people with IDD began transitioning to CCOs from the Medicaid Service Coordination (MSC) program. This transition represented a significant change in system delivery and was considered to be the beginning of the transition into managed care for all New Yorkers enrolled in Medicaid. Despite a formal transition to managed care having not yet occurred, the transition to CCOs offers the opportunity for stronger and more comprehensive coordination of supports and services through Health Home Care Management.

To reduce potential disruption in services, many of the already existing Medicaid Service Coordinators were given the opportunity to transition into new roles as Care Managers in the new CCOs. Initially, enrollment was voluntary and then mandatory for all eligible groups.

While OPWDD considers the transition to this model to have been successful in some ways, the Office continues to consider further efforts that can be undertaken in collaboration with CCOs, DOH, provider agencies, and stakeholders to strengthen care management.

Mainstream Managed Care / Managed LTC Plans

Today, approximately 36,000 people with IDD are enrolled in mainstream managed care (MMC) plans for physical and mental health benefits. MMCs focus on preventive healthcare and provide enrollees with a medical home. People with IDD who are enrolled in an MMC plan may transfer to an MLTC plan if he or she meets the MLTC enrollment criteria or becomes eligible for Medicare. As described above, the MLTC program covers institutional and community-based long-term services and supports and does not currently include OPWDD services.

OPWDD has explored the possibility of including the IDD population in managed care. This was accelerated in 2011 by the New York State "Care Management for All" initiative emerging out of the MRT's proposal, which aimed to move all Medicaid benefits and people served by Medicaid into some form of care management. The Care Management for All Initiative spurred the introduction or expansion of several managed care models, including Managed Long-Term Care, Health and Recovery Plans, and Health Homes. However, several groups of people, depending on their circumstances, were previously exempt or excluded from mandatory enrollment, including individuals enrolled in Medicaid waiver programs (e.g., Care at Home), residents of intermediate care facilities and those individuals qualified and identified to receive program services through OPWDD. In July of 2018, DOH and OPWDD undertook a broader step towards Care Management for All when it required that individuals with IDD be enrolled in a CCO.[5]

Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration

The Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration is a pilot program with a three-way contract between CMS, OPWDD, and DOH. Its purpose is to test the success of delivering services that address the whole person and promote enhanced care coordination for full-benefit dual beneficiaries

[5] https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/cco_overview.pdf

aged 21 and older living in a participating region and who are not already receiving developmental disability services through a waiver, a Program of All-Inclusive Care for the Elderly (PACE), or the Independence at Home Demonstration.

In April 2016, Partners Health Plan (PHP) launched the State's only FIDA-IDD, serving a voluntary membership of approximately 1,700 individuals in the downstate region (New York City, Long Island, Rockland, and Westchester Counties). The FIDA-IDD benefit package consists of a comprehensive array of Medicaid and Medicare services including hospitalization, healthcare, dental, behavioral health, pharmacy, and OPWDD-certified developmental disability services.

While limited in terms of the membership sample, relative to the eligible regional and statewide population base, overall experience for individuals enrolled in the FIDA-IDD Demonstration has been positive. For example, enrollees in the program have reported improved care management and better communication and coordination with their specialists, stating that their Primary Care Physicians (PCPs) are usually or always informed about care received from specialists. However, respondents have also commonly complained about transportation benefits, which some have said were better prior to FIDA because they previously had a choice of transportation providers.[6]

Specialized I/DD Plans – Provider Led

MRT's efforts, along with the continued expansion of managed care to other populations, led to the proposed formation in 2019 of provider-led specialty plans (known as SIP-PLs) certified under Article 44 of the Public Health Law. SIP-PLs were proposed to cover all standard state plan services in the mainstream Medicaid managed care benefit, including acute and primary care, behavioral health services, long-term services and supports, as well as IDD services. It was originally envisioned that some Mainstream plans would offer a specialized IDD plan as a separate line of business.

DOH and OPWDD also released a draft version of the New York State Medicaid Managed Care Organization IDD System Transformation Requirements and Standards to serve Individuals with Intellectual and/or Developmental Disabilities in SIP-PLs. From 2018-2020, the transition to specialized managed care was focused on two areas: (1) improvement in care management processes using a home health model; and (2) creation of a policy framework for the implementation of provider-led managed care.[7] In February 2020, OPWDD issued a revised draft document identifying the qualifications for entities that would become SIP-PL managed care organizations in New York State. However, this process was ultimately paused by the COVID-19 pandemic response efforts and a desire to continue to objectively evaluate the proposition of carving the IDD population into Managed Care.

Membership/Enrollment

Currently, OPWDD coordinates supports for approximately 130,000 people with IDD. Although most Medicaid specialized IDD services are paid through fee-for-service (FFS), approximately 39,000 people with IDD are enrolled in a type of managed care including FIDA-IDD, MLTC, Medicaid Managed Care.

[6] https://innovation.cms.gov/data-and-reports/2022/fai-ny-fida-idd-prelim-firstsecondeval.rpt
[7] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_mco_qual_doc.htm

Nearly 113,000 people with IDD served by OPWDD received their case management services through CCOs.[8] Individuals enrolled in CCOs have a choice of two service options: Health Home Care Management or HCBS Basic Plan Support. The number of people receiving either Health Home or Basic HCBS Plan Support has remained constant at 97% and 3% respectively, since the implementation of CCOs.

Programmatic Performance

OPWDD actively seeks input on regulatory streamlining of operations and oversight to enhance access to and operations of services through regular surveillance and surveying of programs and services. OPWDD uses several outcome measures to assess programmatic performance, which will be further reviewed by OPWDD and Guidehouse as part of this evaluation.

OPWDD Stakeholder Engagement to Date

OPWDD regularly engages with diverse groups of stakeholders to gather perspectives and recommendations on the issues they believe are most important for OPWDD to address. Below is a summary of stakeholder partners with whom OPWDD engages.

OPWDD highly values the input of all stakeholders when making key decisions that impact the population it serves. For example, as part of the 2023-2027 Strategic Plan development, OPWDD held over 30 opportunities for people to provide verbal input. In addition, OPWDD received more than 500 surveys completed by stakeholders, which helped identify the key goals and objectives outlined in Section 2. OPWDD held multiple statewide virtual hearings and numerous remote meetings with targeted constituent groups.[9]

Stakeholders who supported the transition to disability provider-led managed care also were in favor of the integration of developmental disability services, healthcare, behavioral health, and other social care supports as a mechanism for incentivizing high quality and efficient care. Stakeholders who opposed the transition were concerned about the administrative costs associated with managed care. They questioned whether those costs would require reductions in services and supports.

[8] https://opwdd.ny.gov/data/care-coordination-organization-profile
[9] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf

Source: OPWDD 2023-2027 Strategic Plan

The stakeholders also acknowledged that the CCO model needs more time and opportunity to demonstrate success and evolve further into a more integrated model, and urged OPWDD to focus on other challenges to the service system, including: the workforce crisis, improving self-direction, improving care for individuals with complex needs, and housing needs. OPWDD used the stakeholder feedback to create its strategic plan.

Additionally, OPWDD will continue to work with its counterparts in other disability networks and state agencies like DOH, Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), New York State Education Department (NYSED), and the Department of Labor (DOL), to create synergy between systems, share information and data, leverage resources, and provide appropriate services to New Yorkers accessing multiple systems.

Section 4 Service Delivery Models

Relevant State and Federal Statutory/Regulatory Authority, Statutory References

OPWDD provides services and supports to people with IDD through a variety of community and facility-based services. The current utilization of services by people with IDD relies primarily on the Medicaid HCBS waivers and the Medicaid State Plan Fee-for-Service (FFS) delivery model. HCBS is a formal Medicaid State Plan option, giving states the option to receive a waiver of Medicaid rules governing institutional care. Medicaid program waivers offer states additional targeted flexibility to test new approaches to service delivery. Although State Plan options that allow for similar approaches without a waiver have been added to the statute over the years, many states continue to make use of waivers, in part because of the additional flexibilities they provide.

Below we highlight current service delivery authorities with associated descriptions. OPWDD will likely be required to seek CMS' approval to amend existing authorities or develop new authorities if the Office pursues alternative service delivery models. Further, several authorities exist in state statute, some of which will require extension or modification depending on transition planning and decisions related to final product design. States can implement managed care delivery systems under three basic types of federal authorities: State Plan authority [Section 1932(a)], 1915(b) and 1915(c) waiver authority, or Section 1115 waiver authority. Each of these authorities have unique federal regulations states must comply with including having a quality program, providing appeal and grievance rights, reasonable access to providers, and the right to change managed care plans. However, states do have the flexibility to determine statewide application, comparability of services, and freedom of choice.[10]

Table 1. Waiver Programs

Topic	Description	Implication(s) for OPWDD
1915(b)[11]	Provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewide application, and freedom of choice. States typically use two provisions in the law to implement managed care delivery systems.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.

[10] https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html
[11] https://www.macpac.gov/subtopic/1915b-waivers/

Topic	Description	Implication(s) for OPWDD
1915(b)(1)[12]	Primary care case management or specialty service arrangement. This authority allows states to mandate enrollment in a managed care plan or a primary care case management (PCCM) program. Under both models, freedom of choice must be waived to limit the providers through whom enrollees access services.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.
1915(b)(4)[13]	Restriction to specified providers. States may use waivers to limit the number or type of providers who can provide specific Medicaid services – for example, for disease management or transportation. This includes selective contracting by states paying providers on an FFS basis.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.
1915(c) – Home & Community -Based Services	States can develop home and community-based services waivers (HCBS waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.	If OPWDD transitions to a new service model, all services must comply with the HCBS setting rule and the rebalancing of services from institutional care to home care.[14]
1115 Waiver	A demonstration waiver that allows states to test new Medicaid approaches. These waivers are typically designed to demonstrate how changes to program requirements can be used to improve access to care, increase efficiencies, or lower costs without increasing federal Medicaid expenditures.[15]	An 1115 waiver allows OPWDD to implement a new service model that allows the State to expand Medicaid managed care.

Additionally, New York has promulgated relevant statutes governing managed care authority in the State of New York. Some of these statutes will require extension or modification depending on transition planning and decisions related to final product design.

[12] https://www.macpac.gov/subtopic/1915b-waivers/
[13] https://www.macpac.gov/subtopic/1915b-waivers/
[14] https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf
[15] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

Community Integration and Growth of HCBS Services

As OPWDD prioritizes people with IDD receiving person-centered services and supports in community-based settings, it must also make intentional efforts to emphasize the importance of community integration. Community integration supports and enables people with IDD to live, work, and participate in communities of their choice. For people with IDD, this participation also includes full access to civic, religious, educational, economic, and social events occurring in their respective communities. Community integration for persons with IDD and the positive outcomes resulting from such participation, factor heavily in the achievement of positive quality outcomes for state service delivery systems.

Successful rebalancing efforts by states to shift funding and supports from institutional to community-based services, have led to growth in the number of recipients and expenditures for HCBS services. States have made much progress in increasing community options for people with IDD. Today over 75% of people with IDD are receiving services in their home and community. As such, states need to continuously consider how to build HCBS programs to account for anticipated growth and critically evaluate HCBS packages for people with IDD.

High-Impact Policies and Considerations for HCBS Programs for People with IDD

As OPWDD explores transitioning to managed care or other related service delivery models, the Office must take into consideration the impact of state and federal policies and rules and regulations promulgated to support the oversight and operation of the State's IDD service delivery system.

An example of one such consideration is the ruling of the *Olmstead Decision* issued in 1999, which encourages state Medicaid programs to rebalance delivery of LTSS from institutional care to HCBS. In the past 20 years, Medicaid spending has shifted toward HCBS, supported by multiple efforts underway at the federal and state levels to serve more beneficiaries in their communities. With a focus on the Olmstead Decision, OPWDD must determine how potential changes to its service delivery system will impact previous and future rebalancing efforts prior to making such a move. Below we have highlighted several other policies and their implications on changes to the OPWDD service delivery system model.

Table 2. Key National Policies and Their Potential Impact on OPWDD Considerations

Topic	Description	Implication(s) for OPWDD
HCBS Quality Measure Set	The HCBS Quality Measure Set is intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. In doing so, it is expected to support states with improving the quality and outcomes of HCBS.	Historically, CMS and states have struggled to identify a standardized set of quality measures for people with IDD. That is changing as CMS plans to incorporate use of the HCBS measure set into the reporting requirements for the Money Follows the Person (MFP) program and future section 1115 demonstrations. CMS also encourages use of the measure set in 1915(c),1915(i), 1915(j) and 1915(k) authorities. While use of this measure set is voluntary at this time, these changes may require current and future alignment. States are also responsible for establishing quality performance measures for MLTSS programs. In addition to this, states should address key principles when developing MLTSS programs.[16][17]
National Core Indicators (NCI-IDD)	Is a national effort to measure and improve the performance of public developmental disabilities agencies. Performance is measured across four domains: (1) individual outcomes; (2) system performance; (3) health wellness and rights; and (4) family experience.	OPWDD's efforts to measure important elements of person-centered planning, outcomes and satisfaction must be sustained regardless of service delivery model.
HCBS Final Rule Statewide Transition Plan	State plan home and community-based services, and home and community-based settings must have specific qualities (e.g., integrated, privacy, etc.), based on the needs of the individual as indicated in their person-centered service plan. States must also provide conflict-free case management, assuring that assessment and coordination are separate from delivery of services.	The State must ensure that it has proper operations and technology in place to support the HCBS settings requirement. The State will have to ensure that all new services will comply with the final rule. There will also be a need to train all new providers on the rule.

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf
[17] https://www.medicaid.gov/Medicaid/downloads/mltss-summary-elements.pdf

Topic	Description	Implication(s) for OPWDD
Medicaid and Children's Health Insurance Program Managed Care	This final rule advances CMS' efforts to streamline the Medicaid and Children's Health Insurance Program (CHIP) managed care regulatory framework.	OPWDD must ensure appropriate state authorities and final rule compliance measures are in place prior to proceeding with a new MLTSS service delivery model.

Medicaid Managed Care

Managed Care Organizations (MCOs) coordinate and manage care for Medicaid consumers. States pay each MCO a fixed per-member, per-month (PMPM) payment (i.e., capitated payment) for each Medicaid consumer enrolled in that MCO's health plan. These arrangements are risk-based, meaning that if the MCO does a poor job of keeping the consumer healthy and incurs expenses above and beyond what the MCO is paid, the MCO does not receive any more funds from the State. Similarly, if the MCO keeps both consumers healthy and manages service utilization appropriately, it may keep some or all savings from the amount paid by the State. More recently, states have looked to MCOs to provide and coordinate services for more complex populations, such as those requiring LTSS. For the IDD population, these services may include community-based services such as Supported Living, Supported Employment, Housing Stabilization, and Community Integration and Development. Medical and social services are also available to aid individuals with chronic illnesses and significant challenges with performing activities of daily living (ADLs), such as bathing, eating, and toileting, as well as instrumental activities of daily living (IADLs), such as medication management, budgeting, and transportation.

LTSS are delivered in a variety of care settings, which generally fall under two broad categories: institutional (nursing facilities or intermediate care facilities) and community-based (in the home or community settings, such as adult day services). States have been using comprehensive MLTSS programs to manage care for consumers using LTSS, increase access to community-based care, improve member satisfaction and health outcomes, and improve budget predictability. However, no two MLTSS programs are exactly alike. Despite states' increasing adoption of MLTSS, few studies on the value of MLTSS programs have been conducted. States are also mindful of the fact that they will need to carefully monitor the quality of the care provided by the MCOs to these vulnerable consumers.[18]

As of 2021, 22 states, including New York, operate MLTSS programs for various populations. Older adults are the most included population while IDD populations are slowly being integrated nationwide. Among the 22 MLTSS programs that exist:

- 85% include Medicaid primary and acute care
- More than 80% include nursing facility services
- Medicaid HCBS are incorporated in 85%

[18] http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf

- 75% are available statewide
- 25% are in specific regions or counties[19]

Additionally, Ohio and South Carolina operate within the confines of a Financial Alignment Initiative demonstration which coordinates care and aligns benefits for individuals eligible for Medicare and Medicaid although neither of these states include people with IDD in this program. As outlined earlier in Section 3, New York also operates a similar FIDA-IDD program for people with IDD.

Given the unique needs of people with IDD, the decision to transition this population to managed care should be well planned and given appropriate consideration. The provider community for people with IDD is quite different than those serving older adults and people with physical disabilities. Unlike services for older adults, there are very few private pay recipients of IDD services, which makes IDD providers heavily dependent on public resources. Many of the providers started from local advocacy groups, and as a result are often small organizations serving fewer than 50 people. Since services for people with IDD are designed to engage the person fully in their community, there may be different providers for residential versus employment and day services. Moreover, their level of business acumen – ability to set prices, negotiate contracts, and meet stringent accountability outcomes demanded by MCOs – varies greatly across the country. Because the IDD system in most states serves the majority of their participants in home and community settings, not intermediate care facilities for Individuals with Intellectual Disabilities (ICFs-IDD), goals other than rebalancing are typically top of mind for states:

- Increased access to preventive and acute services
- Comprehensive care/service coordination
- Budget predictability and stability.

Managed care may also foster innovation to address social determinants of health (SDOH), also known as social drivers of health, which are "…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risk."[20] As part of their value-add services,[21] MCOs may pay for or support non-medical services such as transportation, housing, and food insecurity. For example, if an MCO's member has asthma, the MCO could offer a home assessment to identify any environmental asthma triggers.[22] Identifying these asthma triggers in the member's home will not only improve their health outcomes but could also reduce healthcare utilization for asthma-related instances.

[19] http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf
[20] https://health.gov/healthypeople/priority-areas/social-determinants-health
[21] Value-add services are services that MCOs offer to their members for which the state does not pay.
[22] https://academyhealth.org/sites/default/files/implementing_sdoh_medicaid_managed_care_may2018.pdf

In 2012, CMS released guiding principles for MLTSS programs using 1915(b) and Section 1115 authorities. Since then, many of these principles have been embedded in the Medicaid managed care regulations.

Table 3. MLTSS: 10 Guiding Principles [23]

Principle	Description
1. Adequate Planning and Transition Strategies	The most effective MLTSS systems are the result of a thoughtful and deliberative planning process. An adequate planning process includes the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.
2. Stakeholder Engagement	Stakeholder engagement and collaboration are critical pieces to ensure the smooth and efficient transition to managed care for these populations.
3. Enhanced Provision of Home and Community Based Services	Community-based LTSS should be delivered in settings that are aligned with requirements for home and community-based characteristics and in a way that offer the greatest opportunities for active community and workforce participation.
4. Alignment of Payment Structures with MLTSS Programmatic Goals	Payment to managed care plans should support the goals of MLTSS programs including the essential elements established in this document and support three goals of improving the health of populations, improving the beneficiary experience of care, and reducing costs through these improvements.
5. Support for Beneficiaries	All beneficiaries, particularly those most vulnerable, need support and education throughout their experience in the MLTSS program. Common support resources for beneficiaries provided by the state at no cost to the beneficiary are enrollment/disenrollment services, including choice counseling and education on additional opportunities for disenrollment, and an advocate or ombudsman to help beneficiaries understand their rights, responsibilities and how to handle a dispute with the managed care plan or state.
6. Person-centered Processes	Ensuring beneficiaries' medical and non-medical needs are met and they have the quality of life and level of independence they desire within the MLTSS program start with the person-centered planning process. Active participation by the beneficiary, or his/her designee, in the service planning and delivery process, meaningful choices of service alternatives, holistic service plans based on a comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to direct their community-based services, fostering independence, with assurances of appropriate supports are critical components that CMS will expect to see in state applications.

[23] https://www.medicaid.gov/Medicaid/downloads/1115-and-1915b-mltss-guidance.pdf

Principle	Description
7. Comprehensive and Integrated Service Package	Managed care plans have more impact on, and ensure quality delivery of, the services covered in their state contract. When all covered services – including integrated physical health, behavioral health, community based and institutional LTSS – are provided through the managed care plan, the managed care plan staff and/or providers developing, and monitoring service plans are able to provide comprehensive person-centered service planning and oversight of care across all available settings.
8. Qualified Providers	As with traditional managed care plans, MLTSS plans are required to have an adequate network of qualified providers to meet the needs of their enrolled beneficiaries.
9. Participant Protections	People with IDD can be especially at-risk for exploitation and abuse, neglect, inappropriate denial of services, and limited participation in the planning of their services and supports. CMS expects states to mitigate these risks through program design and contracts with appropriate health and welfare assurances, a strong critical incident management system, and an appeals process that allows access to continuation of services while an appeal is pending.
10. Quality	The building blocks of a quality MLTSS program include both existing LTSS quality systems and managed care quality systems. Merging these two systems may provide a state with more sophisticated data capabilities and provide a new opportunity to think holistically about beneficiary outcomes. A comprehensive quality strategy and oversight structure that takes into consideration the acute and primary care, behavioral health, as well as LTSS needs of beneficiaries can provide a framework for states to incorporate more meaningful goals into the program that focus on quality of care and quality of life for beneficiaries. Quality oversight of an MLTSS program may be operationalized differently from the fee-for-service system; therefore, states will need to evaluate their resources to ensure the appropriate type and level of staff is available.

Additionally, ADvancing States, which represents the nation's 56 state and territorial agencies on aging and disabilities, released its 2017 "Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities: Strategies for Success"[24] report that highlighted various key factors that are critical for a successful implementation of a MLTSS program for people with IDD including:

- Adequate planning time
- Continuous stakeholder engagement
- Thoughtful program design
- Recognition of the unique needs of people with IDD.

[24] http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf

Fee-For-Service

In an FFS delivery model, providers are paid for each service unit they provide rather than receiving a capitated payment for a specific period of time. This payment model is commonly used in hospitals, clinics, HCBS settings, nursing homes, and other healthcare settings. Cost of care is typically determined by the service provided and complexity of the care. As of 2021, there are 43 states that are FFS for the IDD population[25]. With an FFS delivery model, volume of services is sometimes prioritized, and quality and patient outcomes are not necessarily tied to provider reimbursement. This has led some states to consider transitioning to other service delivery models for the IDD population.

The impetus for New York State MRT was to move all populations receiving traditional Medicaid benefits to managed care in order to reduce cost and improve quality with an emphasis on value-based care and Community Based Organization (CBO) participation via the Value Based Payment (VBP) Road Map. As described above, FFS Medicaid for the IDD population includes traditional provider reimbursement and access to Health Home and HCBS services to improve care coordination; however, state payments are not typically tied to quality or health outcomes.

FFS impacts the following goals from the OPWDD strategic plan:

- **Transform OPWDD's system through innovation and change**
  - *Strengthen quality, effectiveness and sustainability of support and services:* Under FFS, providers are compensated based on the delivery of services to individuals with developmental disabilities and their families. Compensation is not typically tied to quality or health outcomes.
  - *Research and innovation:* Providers are paid based on direct service delivery, making it a challenge for states to incentivize innovation through provider payments. The development of pilots accompanied by the need to evaluate outcomes may be prohibited by the lack of reimbursement for already overburdened providers and nonprofits.
- **Enhance OPWDD's person-centered support and services**
  - *Ensure children, youth, and young adults receive appropriate and coordinated services. Expand support for people with complex needs:* Providers have noted that FFS does not reimburse appropriately for care coordination.
  - *Address gaps in cultural and ethnically diverse communities:* Providers and CBOs have noted that FFS does not compensate appropriately for the administrative cost to identify, address, and reduce the gaps in cultural and ethnically diverse communities. There are limitations in Health Homes and HCBS services to tailor solutions to this unique and complex population.

[25] http://www.advancingstates.org/sites/nasuad/files/2021%20%20Demonstrating%20the%20Value%20of%20MLTSS.pdf

Despite the recent trend in MLTSS, the experience of managed care for people with IDD is more limited and LTSS for people with IDD are frequently among the last services to be incorporated into managed care contracts. While the goals of care integration, improving quality, and encouraging innovation are important to IDD systems, only a few states have fully embraced contracted Medicaid managed care for all IDD services due to several reasons, such as:[26]

- Lack of potential cost savings
- Limited MCO experience serving people with IDD in MLTSS
- Limited state experience to set MLTSS-IDD managed care rates
- Need for meaningful quality measures
- Lack of managed care experience among IDD providers
- Unique role of IDD case management and supports coordination

[26] https://www.ancor.org/wp-content/uploads/2022/08/ancor_mltss_report_-_final.pdf

Section 5 Next Steps for Completing the Final Managed Care Assessment

With the submission of this legislative report, Guidehouse, with the support of OPWDD, will move forward with its assessment of potential service delivery models for people with IDD, including managed care, through a collective and iterative approach focusing on how OPWDD can best position itself to achieve its three goals within the 2023-2027 Strategic Plan:

1. Support people in the most person-centered ways
2. Promote practices that strengthen the workforce and infrastructure
3. Advance systems change and innovation across the State.

The assessment will evaluate how the implementation of managed care, or another delivery system, can assist OPWDD in improving services and supports for people with IDD in New York State. The assessment will include the following three key steps:

1. Environmental Scan, Literature Review, and Data Analysis

To achieve these ends, Guidehouse has begun conducting an environmental scan to supplement and strengthen knowledge of current service delivery models outlined in this report and expand understanding of current MLTSS operations, with a specific focus on current supports for people with IDD. This includes a review of documentation, data analysis, and interviews with internal stakeholders.

To complement our qualitative background knowledge, Guidehouse will review quantitative metrics such as program utilization data, care planning, critical incident, and quality measure data to help us understand whether programs are operating and serving HCBS and MLTSS members as intended, and to assess any gaps in service or benefit design that would need to be addressed for implementation. This step allows us to draw objective conclusions and develop hypotheses about the level of preparedness New York's IDD programs have prior to a change in service delivery model. These conclusions and hypotheses will inform and be tested by stakeholder feedback activities and provide a comprehensive understanding of the needs and experiences of people with IDD and their families.

As part of this assessment, we also anticipate analyzing the following initial data points to assess services, efficiency, and cost effectiveness of the current IDD programs including fee-for-service, FIDA-IDD, and Medicaid Mainstream Managed Care Plans:

- Service utilization trends
- Claims data population analysis of Medicaid enrollment, utilization, and care settings
- Annual expenditures and average spend per member to assess potential risk pool challenges
- Critical incident data to cross reference with clinical utilization trends

- Claims data on hospitalizations, emergency department visits, primary care visits, and behavioral health services to inform the current state of clinical integration.

Following these initial data reviews, collecting rich qualitative data via surveys and interviews will be imperative to determining a well-informed recommendation on the most appropriate service delivery model. Bringing quantitative and qualitative data elements together will offer a full circle view of New York's current state and the potential impact of transitioning the IDD delivery system to managed care.

2. Best Practices and National Trends

Guidehouse will continue to evaluate best practice care management models for the IDD population and transitions to managed care models among a diverse array of states to gain comparative insight on their existing model and structure.

Best Practice and Peer State Literature Review

Guidehouse will continue its document review of publicly available studies and assessments. The research will consider information on care management models, managed care transitions, quality measures and outcomes, and community-based service delivery. We will conduct detailed document reviews of best practice states based on performance (e.g., key performance indicators) and peer states with similar population, structure, and cultural dynamics as New York State. This best practice and peer state research will include an analysis of each selected state across key focus areas, such as:

3. Stakeholder Engagement

Meaningful engagement with diverse stakeholders is a key component of this effort. Input provided by stakeholders in the past has helped OPWDD identify opportunities not otherwise observed by state staff and lead to more effective outcomes. Given the length of time a potential change in service delivery model has been under consideration by OPWDD, a significant volume of stakeholder feedback has already been received about the topic. Guidehouse will begin by reviewing prior stakeholder engagement findings including all notes, summaries, and

comments regarding previous and ongoing stakeholder engagement activities to identify key themes related to managed care or other service delivery models for people with IDD such as:

- Comment or recommendation is within OPWDD's jurisdiction and purview to create change
- Comment is mentioned frequently or identified as high priority by independent commentors
- Comment is relevant to the stakeholder engagement aims and objectives

Through reviewing previous notes and stakeholder engagement results, Guidehouse will identify historical and emerging themes, key stakeholders, and a thorough background of engagement initiatives already undertaken by the State. The results of the review will be used to inform the development of Guidehouse's stakeholder engagement methodology of questions for future stakeholder engagement.

Based on the results of this review, and with the assistance of OPWDD, Guidehouse will develop targeted questions related to the managed care study, focusing stakeholder engagement on four groups:

1. Statutory Advisory Boards
2. New Yorkers with IDD and Natural Support Engagement and their Providers
3. Managed Care Constituency
4. Other Internal, State and Local Government Partnerships.

Statutory Advisory Boards

Given the vulnerable nature of the population OPWDD serves, there are advisory boards that have been established to oversee and support these people with IDD. Guidehouse and OPWDD will engage with these groups to gather important guidance and insights into a potential change in service delivery model.

- The Developmental Disabilities Advisory Council (DDAC) is a key stakeholder that was established within the NYS Mental Hygiene Law and is tasked with providing recommendations on statewide priorities, planning and process evaluations. The DDAC is comprised of self-advocates, providers, and family members.
- The Joint Advisory Council (JAC) for managed care was created to provide input and make recommendations about care improvements and improve transitions of services for their people with developmental disabilities and their families.

New Yorkers with IDD and Natural Support Engagement and their Providers

A study focused on connecting with New Yorkers who rely on OPWDD's services directly will help Guidehouse to understand the implications of any policy or program changes under consideration. Collecting feedback from people with IDD and their families will be key to

understanding the importance of considering how policy changes at the State level will impact services.

This assessment also spans across multiple providers and provider types. It will be critical to involve providers during the project life cycle. In addition to engaging individuals who receive services from OPWDD, OPWDD has already begun to identify a comprehensive and diverse list of waiver providers, associations, and other provider stakeholders with whom Guidehouse will engage. The goal of these engagements is to assess and identify the quality and outcomes of the managed care environment and to identify potential opportunities where managed care may support or hinder OPWDD in achieving its strategic goals.

Managed Care Constituency

Given the current role of managed care across New York for other populations, Guidehouse may also engage representatives of MCOs to better understand their perspective around how certain service delivery models may best benefit New Yorkers with IDD. This group may include CCO and FIDA-IDD leaders and employee representatives.

Other Federal, State and Local Government Partnerships

Guidehouse may also have conversations with CMS to understand CMS expectations if a transition to managed care were to take place, and to cultivate a positive and engaging relationship with CMS to ensure the most beneficial technical assistance is available. In addition to CMS, it will also be beneficial to discuss the potential transition with state agencies and local government partners.

OPWDD will also conduct ongoing education and stakeholder engagement activities with the general public. Educating the public is particularly beneficial for policy and program initiatives involving the IDD population and understanding what service delivery model may be best for the population. The IDD population is a vocal and engaged group that is very active in policy decisions regarding their care. Continuous education efforts would provide OPWDD the opportunity to explain policy decisions and gain buy-in from key stakeholder groups.

Final Report

The Final Report will be based on comprehensive information and research collected throughout the study and significant stakeholder engagement, as outlined above. From a compilation of quantitative and qualitative information, the Final Report will present data-driven recommendations for discussion among stakeholders and decision-making of what service delivery model can most effectively support the individualized needs of people with IDD and help to achieve OPWDD's goals.

As Guidehouse prepares the Final Report and recommendations, we will work with OPWDD to explore recommendations on service delivery models, including managed care, and program requirements that yield progress toward the goals outlined in the 2023-2027 Strategic Plan. Guidehouse intends to include the following elements in the Final Report:

- **Service Delivery Model Study Methodology and Findings:** Comprehensive summary of the service delivery study methodology and findings after completing all research and

stakeholder engagement activities, focusing on managed care and other options currently implemented nationally.

- **OPWDD Program Goals:** Detailed perspective of OPWDD program goals, objectives and measurements of success to execute and monitor OPWDD's progress towards achieving goals based on the recommended service delivery system.
- **Final Recommendations:** Recommended next steps for selection and implementation of a service delivery model. This will include key program requirements of the recommended service delivery model to successfully serve the IDD population across New York.

Guidehouse appreciates OPWDD's partnership and collaboration in the development of this Initial Report and looks forward to working with OPWDD and the IDD stakeholder community to complete our assessment and Final Report.

Healthcare Modernization Listening Tour Findings and Considerations

In Partnership Between:

TN Tennessee State Government & NAVIGANT

October 8, 2019

Table of Contents

Section 1 Executive Summary

Under direction from Governor Lee to develop a comprehensive plan to improve access to healthcare for Tennesseans, the Commissioner of the Tennessee Department of Finance and Administration, Stuart McWhorter, held four Listening Tour sessions across Tennessee focused on critical healthcare topics, including chronic conditions, rural health, price transparency, and innovation.

> *"We will work with patients, providers, and payers to establish Tennessee as a world-class healthcare market for our people using transparency and competition."*
> *- Governor Bill Lee, State of the State Address*

Figure 1 below summarizes the identified themes from the Listening Tour and policy options for consideration. This figure also shows potential alignment across the policy options for consideration, since implementation of a particular program or strategy may impact multiple areas. As such, joint stakeholder collaboration will be critical for success.

Figure 1: Summary of Identified Listening Tour Themes and Related Potential Policy Options

Theme & Policy Options for Consideration	Theme 1 – "Transportation"	Theme 2 – "Technology to Support Chronic Care"	Theme 3 – "Access in Rural Areas"	Theme 4 – "Social Determinants of Health"	Theme 5 – "Transparency in Healthcare"
Theme 1 – Transportation is a significant barrier to care.					
Evaluate public and private options to increase access		✓	✓	✓	
Provide more services at home		✓	✓	✓	
Engage all State agency partners in improving access to healthcare services			✓	✓	
Theme 2 – Technology, including telehealth, can be a component of the solution to address access issues and a tool for chronic care management, including in rural areas of the State.					
Assess infrastructure to support telehealth			✓		
Leverage telehealth	✓		✓		
Leverage telemonitoring	✓		✓		
Use telementoring solutions	✓		✓		

Theme & Policy Options for Consideration	Theme 1 – "Transportation"	Theme 2 – "Technology to Support Chronic Care"	Theme 3 – "Access in Rural Areas"	Theme 4 – "Social Determinants of Health"	Theme 5 – "Transparency in Healthcare"
Theme 3 – There are significant healthcare access barriers in rural communities, including the lack of providers.					
Expand healthcare workforce development programs		✓		✓	
Expand capacity of the existing healthcare workforce		✓		✓	
Theme 4 – Social determinants of health will be important to address.					
Align state, private, and public entities	✓		✓		
Promote awareness of and action on social determinants of health and comprehensive care	✓		✓		✓
Theme 5 – Greater transparency in healthcare may improve patient outcomes and experiences.					
Evaluate policy solutions to address surprise billing			✓		
Evaluate solutions to support healthcare purchasing				✓	
Educate Tennesseans on insurance concepts				✓	

In addition, Tennessee can consider county- and community-specific characteristics in its implementation approach. In many cases, communities struggle with multiple healthcare and social determinant challenges simultaneously, such as low provider availability, low rates of vehicle ownership, high rates of adult smoking, and limited access to exercise opportunities.

"One size fits all" approaches that fail to account for these unique community circumstances, such as implementing a ride-share program in a county with low vehicle ownership, may not be feasible programs or strategies for these communities. Additional barriers, including geography and economic stability, could hinder a program or strategy's success.

In this report we present for each theme from the Listening Tour:

1. A summary of the identified theme from the Listening Tour
2. A brief summary of the national and Tennessee landscape
3. Potential options for consideration to address the theme

Section 2 Introduction

Goals of Tennessee Healthcare Modernization

On March 4, 2019, Governor Lee delivered the State of the State Address and shared a goal for Tennesseans to have affordable access to high-quality healthcare. Tennessee ranks 42nd in the nation in overall state health rankings[1], and has significant room for improvement on a number of health measures in comparison to other states.

The State's goal is to understand the root cause of the issues preventing Tennessee from being a healthier, and therefore more prosperous State.

"...every Tennessean should have access to high-quality healthcare they can afford. This is an ambitious goal that no state has accomplished, and Tennessee will not accomplish it overnight. We will work with patients, providers, and payers to establish Tennessee as a world-class healthcare market for our people using transparency and competition."

- Governor Bill Lee, State of the State Address

Figure 2: Significant Room for Improvement for Tennessee on Key Health Indicators[2]

To start the State down a path to high-quality and modernized healthcare, the Governor directed the Commissioner of the Tennessee Department of Finance and Administration, Stuart McWhorter, to work with patients, providers, and payers to prioritize critical short- and long-term strategies to make Tennessee a "world-class" healthcare market. With this in mind, Commissioner McWhorter and other agency Commissioners held four Listening Tour sessions across Tennessee that discussed various topics, including chronic conditions, rural health, transparency, and innovation. The participating Commissioners included:

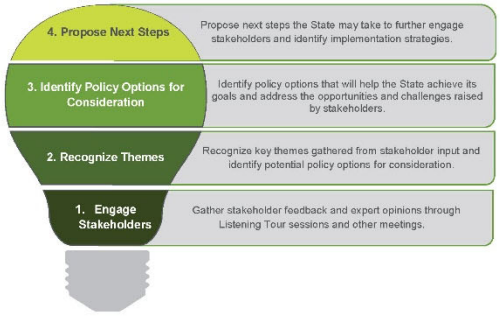
- Commissioner Stuart McWhorter, Department of Finance and Administration
- Commissioner Danielle Barnes, Department of Human Services
- Deputy Commissioner Carter Lawrence, Department of Commerce and Insurance
- Commissioner Jennifer Nichols, Department of Children's Services

- Commissioner Dr. Lisa Piercey, Department of Health
- Director Gabe Roberts, TennCare
- Commissioner Bob Rolfe, Department of Economic and Community Development
- Commissioner Brad Turner, Department of Intellectual and Developmental Disabilities
- Commissioner Marie Williams, Department of Mental Health and Substance Abuse Services

The Listening Tour was a first step to having candid conversations with Tennesseans who are the closest to healthcare's most complex issues.

Purpose of the Listening Tour Findings and Considerations

Stemming from the Governor's mission, the key goals of the Listening Tour Findings and Considerations include:



Overview of Stakeholder Engagement Efforts

In July and August 2019, Commissioner McWhorter hosted four Listening Tour sessions with more than 200 attendees across the State. Each session consisted of three panels tailored to different stakeholders: patients, providers, and payers.

Figure 3: Listening Tour Sessions Held Across Tennessee

Date	Host	City	Time
July 17, 2019	Cleveland State University	Cleveland	10:15 am to 3:00 pm
July 24, 2019	Austin Peay State University	Clarksville	10:15 am to 3:00 pm
July 31, 2019	University of Tennessee Health Science Center	Memphis	10:15 am to 3:00 pm
August 12, 2019	Lipscomb University	Nashville	10:15 am to 3:00 pm

In addition, the State hosted approximately 50 one-on-one or small group meetings with stakeholders to collect in-depth feedback and perspective on opportunities to improve healthcare in Tennessee.

Section 3 Key Themes from Stakeholder Feedback and Related Potential Policy Options

Based on the information and feedback gathered through the Listening Tour and one-on-one meetings with patients, providers, and payers, we identified five themes from the Listening Tour that the State may consider addressing in its healthcare modernization plan:

- Transportation is a significant barrier to care.
- Technology, including telehealth, can be a component of the solution to address access issues and a tool for chronic care management, including in rural areas of the State.

"[in regard to crisis services] If you are in Memphis and there is a bed open in Chattanooga, how do you get there? We don't have a way to get a person who has just overdosed into services."

- Association Representative

- There are significant healthcare access barriers in rural communities, including the lack of providers.
- Social determinants of health will be important to address.
- Greater transparency in healthcare may improve patient outcomes and experiences.

This report presents each theme, the national and Tennessee-specific landscape regarding the theme, and potential policy options for consideration. The policy options should *not* be considered exhaustive and are intended to start a dialogue between the Governor's Office, relevant State agencies, and any potential implementation partners.

In addition, we have identified examples of relevant initiatives from the Federal government, other states, and within Tennessee. This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Theme 1: Transportation is a significant barrier to care.

The lack of reliable and affordable transportation has been well established as a barrier to accessing health services, and impacts self-management and health decision-making for individuals with chronic health conditions.[2] Inadequate transportation can also lead to costly hospitalizations. By improving access to reliable and affordable transportation for Tennesseans with complex health needs or those living in rural areas, the State can increase access to health services and potentially reduce health costs.

Transportation was a recurring theme across all Listening Tour sessions. Listening Tour panelists and attendees cited concerns about the impact that the lack of transportation has on the health of patients. For example:

- Patients, providers, and payers have been faced with transportation challenges, including access, long wait times, lack of accountability among transportation vendors, grievances, and patient dissatisfaction.
- The lack of transportation in rural areas hinders hospital discharge planning and timely discharge efforts, which increases the length of stay for patients and costs.
- Substandard transportation causes difficulty for patients to access available care and resources (e.g., a patient cannot travel to a follow-up appointment and, as a result, is readmitted).

During the Listening Tour, the Anti-Kickback Statute[3] was cited as preventing hospitals from arranging transportation to other facilities as it may be viewed as an inducement. However, there are circumstances that allow safe harbor for hospitals and other selected providers that seek to provide transportation to patients, provided that they meet the requirements under 42 CFR 1001.952(bb).

The Listening Tour also suggested potential strategies, such as establishing public-private partnerships with ride-share companies (e.g., Lyft, Uber) to further serve patients, and partnering with relevant state agencies, with the goals of adding flexibility, reliability, and availability to the healthcare delivery system.

[3] The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward the referral of business reimbursable under Federal healthcare programs.

Policy Landscape – Transportation Policies and Programs

National

Transportation is a focus for states, healthcare providers, hospitals, and private companies:

- **States:** States such as Arizona and Florida have implemented programs relating to transportation provider partnerships for non-emergency medical transportation (NEMT) services. These partnerships are gaining traction through business cooperation rather than state legislation. Despite the trend of using ride-sharing companies as a transportation option, there is limited data to demonstrate their effectiveness and impact on health outcomes.[5] With regard to Medicaid, these initiatives have only been implemented in 2019, so it is too early to determine the long-term effectiveness of these programs.
- **Hospitals:** The American Hospital Association is advocating that hospitals are in an ideal position to initiate changes in transportation given their role in the community and their robust community relationships. Hospitals can begin this process by reviewing community health needs assessments and integrating transportation into their own strategic plans. Subsequently, hospitals can partner with community organizations and other stakeholders to provide direct transportation services. The American Hospital Association cites several case studies on hospitals and health systems and their interventions to successfully reduce transportation barriers in their communities.[6]
- **Private Companies:** Private ride-sharing companies such as Uber and Lyft are also contracting directly with state Medicaid programs and private payers serving Medicare and Medicaid enrollees. Lyft has already partnered with several healthcare organizations, such as the Blue Cross Blue Shield Institute and LogistiCare, to bring NEMT to certain Medicare Advantage plans.[6] Uber partnered with MedStar Health in the Washington D.C. area and Hackensack University Medical Center in New Jersey.[7]

  Ford Motor Company is also entering the space, with its GoRide program. The program was initially designed to serve five skilled nursing facilities in Dearborn, Michigan, but within a year, it expanded to serve multiple hospitals in the region. GoRide is currently expanding into Ohio, and plans to expand in several major cities in Florida by the end of 2019 and four other states in 2020.[8]

  Several new technology start-ups, such as RoundTrip, Circulation Inc., and Kaizen Health, are also trying to meet the transportation needs of seniors, low-income patients, and other patients with substance abuse conditions, cancer, and renal disease. Each start-up has created an online portal that complies with federal regulations to make it easy to book and track patient rides.[9]

Putting Strategies into Practice

One panelist provided an example of working with the local transit authority to add a bus stop in Memphis so pregnant women could attend obstetrical appointments, which reduced the infant mortality rate.

Mobile crisis programs were also mentioned during the Listening Tour as a strategy that may reduce the number of incarcerated children and children becoming wards of the State. This mirrors the success that New Jersey has experienced, eliminating the need for psychiatric residential treatment facilities (PRTFs) and greatly reducing foster care placements in New Jersey. Mobile crisis units help address transportation issues because the intervention takes place at home. System of Care grants are available to provide mobile crisis services and additional wrap around services.

Tennessee

In Tennessee, the Tennessee Department of Transportation (TDOT) works to promote public transportation by providing both financial and technical assistance to transit agencies and transit projects. Seventeen areas of the State created Coordinated Public Transit – Human Services Transportation Plans that identify the transportation needs of seniors and individuals with disabilities in their area. Each of these Transportation Plans is available on TDOT's website and provide an overview of transportation options for the area.[10]

Finally, Tennessee's Medicaid program, TennCare, covers NEMT for its enrollees. NEMT provides transportation for Medicaid enrollees to access non-emergency medical services such as follow-up doctor appointments.

Access to Transportation – National and Tennessee Data

Access to transportation plays a significant role in the ability for individuals to access healthcare services. Based on publicly available data on travel time and the location of hospitals, we find that a lack of access to transportation has the greatest impact on rural communities.

National

At the national level, many rural and urban residents report that access to good doctors and hospitals is a major problem:[11]

- Rural Americans: 23 percent
- Suburban Americans: 9 percent
- Urban Americans: 18 percent

In late 2018, another Pew Research Center survey identified the average time and distance to the nearest hospital by type of area, as shown in Figure 4.

Figure 4: National Average Time and Distance to the Nearest Hospital for Americans[12]

Type of Area	Average Travel Time	Average Distance
Rural	17.0 minutes	10.5 miles
Suburban	11.9 minutes	5.6 miles
Urban	10.4 minutes	4.4 miles

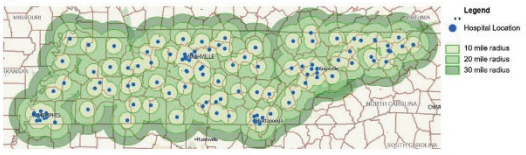
A 2019 study conducted by the University of Kentucky found the mean transport time to a hospital in rural zip codes increased from 14.2 minutes before the hospital closure to 25.1 minutes after the closure, a 76 percent increase. The time increase is greater for patients in rural zip codes over 64 years old. The mean time for these senior citizens increased from 13.9 minutes before hospital closure to 27.6 minutes, nearly doubling the transit time to the hospital.[13]

There is a direct relationship between distance to a hospital and patient mortality in cases of emergency. According to an observational study in the *Emergency Medicine Journal*, "… increased journey distance to [the] hospital appears to be associated with increased risk of mortality… a [six mile] increase in straight-line distance is associated with a one percent absolute increase in mortality."[14] From a national perspective, this association points to an increased risk to rural residents in need of emergency care.

Tennessee

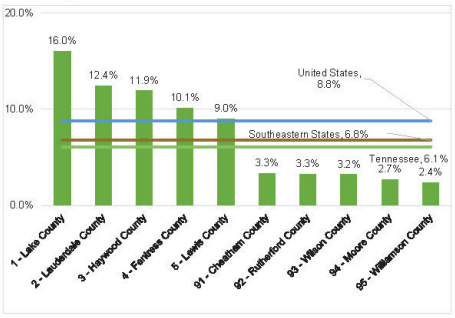
In Tennessee, many residents live farther than 10 miles from the nearest hospital. Nearly all Tennesseans live within 30 miles of a hospital. In Figure 5 below, all Tennessee acute hospitals are represented by a blue dot. This figure shows the distance to the nearest acute care facility within 10, 20, and 30 miles.

Figure 5: Tennessee Acute Care Facility Location as of 2017[15]



Vehicle ownership rates by household help identify Tennessee counties where residents may have difficulty accessing healthcare services. In Tennessee, 6.1 percent of households do not have a vehicle. However, there are counties with significantly higher and lower proportions of households with vehicles. In Figure 6, we show the five counties with the highest and lowest vehicle ownership rates. Counties with the lowest rates of vehicle ownership are predominantly rural – such as Lake County, where 16 percent of households do not own a car. This transportation gap underscores the need for community-specific solutions when addressing access to healthcare. For example, ride-sharing options may not be feasible in communities where residents do not own cars.

Figure 6: County Rankings by Percent of Population with No Vehicle Available in Tennessee, 2017[b, 16]



Potential Policy Options Related to Theme #1

A lack of transportation services can be addressed multiple ways depending on the desired objective and outcome. To address transportation issues, the State does not necessarily need to provide more transportation services itself but rather, allow and support an environment where consumers can access healthcare services at the right time and place with the most appropriate healthcare professional. In Figure 7, we identify three potential policy options for consideration to improve transportation services in the State.

Figure 7: Potential Policy Options to Address Access to Transportation

Policy Option	Rationale for Policy Option
1. *Evaluate public and private options to increase access to transportation services for high need individuals in high need communities*	Increasing access to reliable and affordable transportation can eliminate barriers to health services and enable individuals to make healthy life choices, leading to healthier populations and a reduction in healthcare spending.

[b] Southeastern States are defined as Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, and Tennessee

Policy Option	Rationale for Policy Option
	Public options include increasing the number of bus routes or rerouting public transportation services, so they have stops near health access points, grocery stores, and parks. Private options include partnerships with ride-share and cab companies to provide transportation services for primary care visits, grocery shopping, and recreational events.
2. *Address lack of transportation access by providing more services at home*	Providing health services and delivering healthy foods directly to patients in their homes can improve population health, increase access to healthcare services and healthy food options, and reduce healthcare spending.
3. *Engage all State agency partners in improving access to healthcare services*	Other state agencies have knowledge of current transportation projects and are already working on improving access to healthcare services. Their insight will be valuable when developing potential strategies and coordinating with them will create efficiencies.

Examples of State and Federal Initiatives

Figure 8 below details a sample of current state and Federal initiatives related to transportation. This table is not an exhaustive list of current initiatives.

Figure 8: Examples of State and Federal Initiatives

Examples of State and Federal Initiatives[c]
• ***Tennessee:*** Tennessee Carriers Inc., which brokers NEMT for TennCare members statewide, launched a one-year pilot program with Lyft in August 2019 to address transportation shortages in Shelby County and reduce the burden on the network of conventional transport providers.[17]
• ***Tennessee:*** In February 2019, Mental Health Cooperative opened a new facility that houses a crisis walk-in center, a crisis stabilization unit, crisis respite, and will serve as the headquarters for Davidson County's mobile crisis response team.[18] This facility is open 24/7 and is available at no cost to adults and children.[19]
• ***Arizona:*** The Arizona Health Care Cost Containment System announced in May 2019 that it would allow Medicaid recipients to use their benefits to pay for Lyft rides relating to medical appointments. Uber is also applying to become a transport provider.[20]
• ***Delaware:*** The Delaware Division of Substance Abuse and Mental Health offers a crisis intervention service that covers the entire state, is available 24/7, and is for adults 18 years or older. The locations are through crisis intervention service centers, community mental health centers, recovery response centers, and emergency rooms.[21]
• ***Florida:*** Effective July 1, 2019, Florida authorized certain transportation network companies like Lyft and Uber to provide NEMT services for Medicaid recipients under specific circumstances. It passed unanimously in both legislative chambers.[22]

[c] This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Examples of State and Federal Initiatives[c]
• ***Indiana, Kentucky, and Ohio*** developed a Coordinated Public Transit Human Services Transportation Plan together in 2012 to address transportation needs for the elderly and individuals with disabilities living in the Cincinnati region.[23]
• ***Kentucky:*** Taylor Regional Hospital identified a need for transportation after a high number of missed appointments. The hospital initiated a hospitality van service for patients facing transportation issues. The vans pick-up and drop-off patients at the hospital, dialysis centers, cancer centers, rehabilitation centers, and other facilities. Although the vans are owned by the hospital, drop-off and pick-up do not have to be at hospital-owned facilities. Additional community organizations sponsor gas.[24]
• ***Massachusetts:*** Massachusetts has contracted specific providers for Mobile Crisis Intervention, which is the youth-serving (under 21 years old) component of an emergency service program. The intervention is mobile, short-term, on-site and face-to-face, with the State providing additional guidelines on engagement and follow-up care. Providers are outpatient hospitals, community health centers, mental health centers, and other clinics.[25]
• ***New Jersey:*** New Jersey's Mobile Response and Stabilization Services was created to support youth/children and their families who are experiencing emotional or behavioral issues. The program's support includes an immediate, on-site intervention, resource planning and linkage, and prevention strategies, closing behavioral health gaps in time and distance.[26]
• ***Oregon:*** Since 2012, agency leaders at the Oregon Department of Transportation (ODOT) and the Oregon Health Authority (OHA), which houses the Public Health Division (PHD), jointly began considering ways to improve population health and meet their respective agency goals. The agencies established memorandums of understanding (MOUs) to formalize the relationship, coordinated the use of funds, and developed shared accountability metrics to track progress towards public health goals.[27]
• ***U.S. Department of Transportation's Federal Transit Administration (FTA):*** The agency announced in May 2019 that it is distributing approximately $9.6 million to 37 projects led by transit agencies, government agencies, and nonprofit organizations to "support innovative transportation solutions to expand access to healthcare." FTA's Access and Mobility Partnership Grants focus on solutions to improve access to medical appointments, healthy food, and paratransit services. In Tennessee, the Southeast Tennessee Human Resource Agency will receive funding to "purchase wheelchair lift-equipped vans to transport people with disabilities to work, school, recreation, medical services, and other essential services."[28]
• ***Cigna-HealthSpring:*** Cigna-HealthSpring partners with Lyft to transport select Medicare Advantage members to and from doctors and pharmacies. This partnership began in May 2017 and resulted in 14,500 transports in Alabama, Georgia, Maryland, North Carolina, Pennsylvania, Tennessee, Texas and the District of Columbia between May and November 2017.[29]

Theme 2: Technology, including telehealth, can be a component of the solution to address access issues and a tool for chronic care management, including in rural areas of the State.

Telehealth[d] and telemedicine strategies have the potential to decrease costs and change the way consumers interact with the healthcare system. However, Listening Tour participants indicated that there are several barriers to overcome, including:

- Lack of broadband infrastructure in some communities,
- Interoperability issues, and
- Likelihood of technology quickly becoming out of date.

During the Listening Tour, participants expressed that:

- The State can consider expanding telehealth and telemedicine models to address access issues and support whole-person care management.
- Technology may be leveraged across the State when possible (e.g., Project ECHO (Extension for Community Healthcare Outcomes)), while acknowledging that there are still barriers to overcome (e.g., access restrictions, data interoperability issues, payment issues, and technology quickly becoming outdated).
- Explore the use of realistic technology solutions (e.g., smartphones) to enable the community to take care of itself and to supplement chronic care management efforts by payers and providers.
- Telehealth success is dependent on both administrative and information technology support.
- Information systems across Tennessee are fragmented. The State may focus on how to help organizations receive data and information to make meaningful decisions.

> *"I need telehealth to work well, from a technological and regulatory standpoint. Telehealth is critical and access to broadband infrastructure is critical to multiple industries, not just healthcare."*
>
> - *Provider and Research Institution Representative*

[d] Tennessee Code, Title 56, Chapter 7, Part 10 defines "Telehealth" as "(a) The use of real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when: i) such provider is at a qualified site other than the site where the patient in located; and ii) the patient is at a qualified site, at a school clinic staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section, or at a public elementary or secondary school staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section; and, (b) does not include: i) an audio-only conversation (i.e. phone call) ii) an electronic mail message; or iii) a facsimile transmission.

Two panelists also offered examples of how telehealth enabled schools and law enforcement to provide healthcare and manage behavioral health issues resulting in fewer school absences and reduced jail time.

Policy Landscape – Telehealth Policies and Programs

National

There is significant interest in furthering telehealth initiatives as a tool to combat chronic disease and address barriers to healthcare access at the national level. In July 2019, the Federal Communications Commission approved the Connected Care Pilot Program, a three-year, $100 million initiative focusing on expanding telehealth programs. This pilot focuses on supporting underserved populations, including rural residents and veterans, securing technology and broadband resources to launch remote patient monitoring programs, and will cover up to 85 percent of the costs of broadband enabled telehealth for patients.[30]

There also remains interest in passing additional legislation to support rural providers. For example, in April 2019, the Rural Health Clinic Modernization Act was introduced to classify rural health clinics as distant site providers, enabling them to add more professional services to their telehealth platforms.[31] Tennessee Senator Marsha Blackburn has also proposed the Telemedicine Across State Lines Act which would establish a national telehealth program and a five-year grant to push telemedicine programs into rural communities.[32]

In addition, the American Medical Association recently encouraged Project ECHO and the Child Psychiatry Access Project (CPAP) implementation in academic health centers and community-based primary care physicians.[33] Models such as Project ECHO, which use a partnership model to share knowledge from experts with community providers to provide specialty care, are becoming more common and are currently in use within Tennessee.

Another issue is the broad inconsistency among telehealth programs. Some states incorporate telehealth-related policies into law, while others update Medicaid guidelines through their administrative powers. States have also struggled with developing a cohesive and comprehensive telehealth strategy, showcasing the complexities of addressing statewide healthcare issues.[34]

Tennessee

On January 1, 2019, Tennessee joined the Interstate Medical Licensure Compact along with 29 other states, including Washington D.C.[35] The goal of the Compact is to expand the practice of telemedicine by making it easier for physicians licensed in other states to treat Tennessee patients and for Tennessee physicians to become licensed in other states.

Tennessee includes the following under the definition of eligible sites:

- The office of a healthcare services provider,
- A hospital licensed under Tennessee Code Title 68. Health, Safety and Environmental Protection,
- Rural health clinics compliant with federal Medicare regulations,

- A federally qualified health center,
- A school clinic staffed or at a public elementary or secondary school appropriately staffed and equipped,
- Any facility licensed under Tennessee Code Title 33. Mental Health and Substance Abuse and Intellectual and Developmental Disabilities, or
- Any location deemed acceptable by the health insurance entity.[36]

Three Tennessee institutions have established four Project ECHO programs across the State targeting different focus areas.

Figure 9: Project ECHO Programs Operating in Tennessee

Institution	Focus Area
4 Breath 4 Life	The Helping Babies Breathe framework developed a neonatal resuscitation curriculum for resource-limited circumstances.[37]
East Tennessee State University (ETSU)	The ETSU Quillen College of Medicine, Department of Pediatrics is developing a program based on the American Academy of Pediatrics Project ECHO model to enhance the partnership and co-management of pediatric conditions between primary care and ETSU pediatric specialists.[38]
	ETSU's Project ECHO Buprenorphine Medication Assisted Treatment (BMAT) aims to improve access to patients suffering from opioid use disorder (OUD) through a six-week series consisting of educational sessions and case presentations for family medicine physicians and nurse practitioners.[39]
Vanderbilt University	From June 2017 through November 2017, Vanderbilt's Kennedy Center offered twice-monthly sessions to connect autism specialists with community primary care providers through a virtual learning network called ECHO Autism. Chart review was also conducted at four different points over the project time period.[40] Following these efforts, the Kennedy Center team conducted a 10-site cluster randomized trial (CRT), involving over 140 providers. Through this trial, they observed an increase in autism screening, general developmental screening, autism knowledge, and overall self-efficacy. There was a decrease in number of perceived barriers for caring for children with autism.[41]

Access to Technology and Internet – National and Tennessee Data

The adoption rates of technology and telehealth at the national and State levels highlight a variance between urban and rural areas. As Tennessee considers telehealth initiatives as a way to expand access to care for Tennesseans who lack reliable transportation, it will be critical to ensure technology and internet access in rural areas.

National

Computing devices and internet access are critical to the use of technology to support healthcare and the delivery of telehealth services. The Office of the National Coordinator for Health Information Technology (ONC) states that access to broadband internet is a necessary tool for telehealth programs. Sufficient broadband is needed to transmit imaging technology and peripherals.[42]

In Figure 10, we show that 58 percent of Americans living in rural areas find that access to high-speed internet in their local community is a "major" or "minor" problem. In addition, as shown in Figure 11, adults living in rural areas are less likely to have high-speed internet at home or own a smartphone.

Figure 10: Percent of Adults Indicating that Access to High-Speed Internet is a Problem in their Area, 2018[43]

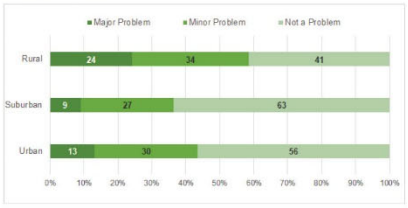
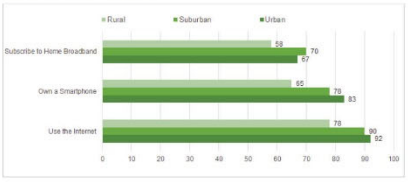


Figure 11: Percent of Adults who Subscribe to High-Speed Internet, Own a Smartphone, and Use the Internet, 2018[44]



Tennessee

Consistent with national findings, rural counties in Tennessee have the greatest internet and computing device shortages. Figure 12 highlights the variabilities in computing device ownership between rural and urban counties. The percentage of the population owning at least one computing device, such as a computer, tablet, or smartphone is highest near major metropolitan areas such as Nashville and Knoxville. Figure 13 shows the five counties with the highest and lowest percentages of the population owning at least one computing device, such as a computer, tablet, or smartphone. The five lowest rated counties for computing device ownership scored approximately 20 percentage points below the national average and more than 15 percentage points below the Tennessee average.

Figure 12: Tennessee County Map by Percent of Population with One or More Computing Devices, 2017[45]

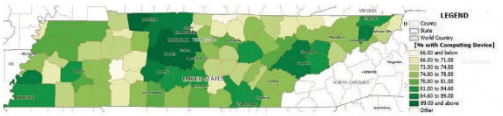
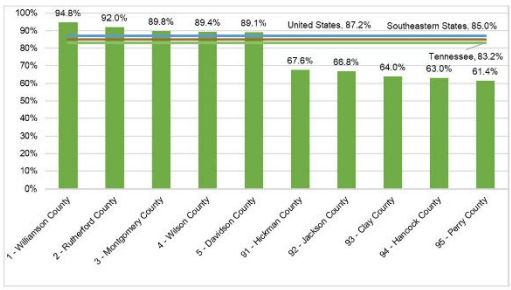


Figure 13: Tennessee County Rankings by Percent of Population with One or More Computing Devices, 2017[e, 46]



In addition, internet subscription rates are lower among rural counties than urban counties, as shown in Figures 14 and 15. For example, Hancock County ranks lowest in Tennessee for the percentage of population with an internet subscription (40.6 percent). This contrasts with the top five counties, in which more than 80 percent of the population has an internet subscription.

[e] Comparison Southeastern states include Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, and South Carolina.

Figure 14: Tennessee County Map by Percent of Population with an Internet Subscription[47]

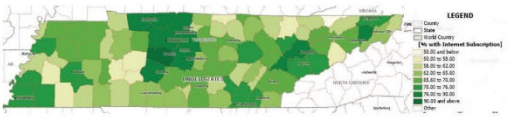
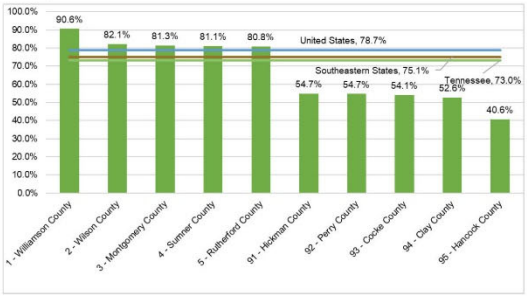


Figure 15: Tennessee County Rankings by Percent of Population with an Internet Subscription[f, 48]



Potential Policy Options Related to Theme #2

Telehealth can be defined in multiple ways and deployed to combat a variety of problems. The three policy options for consideration listed in Figure 16 assume a widely defined interpretation of telehealth that includes telemonitoring patients, telementoring providers, and redesigning care delivery to address access to affordable healthcare.

[f] Comparison Southeastern states include Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, and South Carolina.

Figure 16: Potential Policy Options to Support Technology and Telehealth Solutions

Policy Option	Rationale for Policy Option
1. *Assess supporting infrastructure for telehealth services*	Telehealth solutions rely on a technology backbone and device connectivity to be successful. Understanding which communities have the necessary infrastructure is imperative before implementing telehealth programs.
2. *Leverage telehealth solutions to help patients overcome barriers to access*	Telehealth can increase access to physical and behavioral health services by eliminating barriers to access including transportation issues, availability of local providers, and access to specialty services.
3. *Leverage telemonitoring solutions to help providers and patients manage chronic conditions*	Telemonitoring of vital signs and key health indicators can help patients and providers work more closely on managing an individual's chronic condition, which will lead to fewer emergency visits and high-cost encounters.
4. *Use telementoring solutions to help providers deliver the best care to their patients*	Telementoring can enable providers in rural areas to work with experts that are not located in their communities to provide the highest level of care to their patients. Telementoring can also help to address provider shortages in Tennessee by serving as a support mechanism for providers working in rural communities.

Examples of State and Federal Initiatives

Figure 17 below details a sample of current state and Federal initiatives related to technology and telehealth. This table is not an exhaustive list of current initiatives.

Figure 17: Examples of State and Federal Initiatives

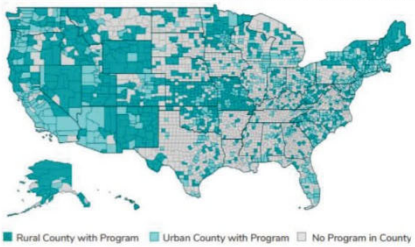
Examples of State and Federal Initiatives[g]
• ***Tennessee:*** The Tennessee Broadband Accessibility Act of 2017 launched efforts to support the adoption of broadband in unserved areas across Tennessee. The legislation focused on three areas: investment, deregulation, and education.[49] The Tennessee Department of Economic and Community Development (TNECD) is working with grantees to expand broadband service to more than 8,300 households and businesses in 17 counties across Tennessee.[50]
• ***Tennessee:*** Google Fiber (high speed internet access) has also been implemented in Nashville. The Google Fiber program brings Google's "…fastest Internet speeds to organizations like libraries, community centers, and nonprofits."[51] There may be opportunities to leverage Google Fiber's infrastructure to bring broadband to rural areas of the State.

[g] This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Examples of State and Federal Initiatives[g]
• ***29 states, including Tennessee, and Washington D.C.*** have adopted the Interstate Medical Licensure Compact which allows for an Interstate Commission to conduct an expedited licensing process for other state license applications.[52] Tennessee is also a member of the Nurses Licensure Compact, Recognition of EMS Personnel Licensure Interstate Compact, and Physical Therapy Compact.[53,54,55] Twelve states are also members of the Psychology Interjurisdictional Compact, which Tennessee does not participate in.[56]
• ***Eight state medical or osteopathic boards*** issue special licenses or certificates for telehealth, allowing out-of-state providers to offer telemedicine services. While Tennessee allows special licenses for osteopathic, the offer is not available to other medical professionals.[57]
• ***Alaska:*** Beginning in September 2018, the State of Alaska partnered with Teladoc to provide non-emergent telehealth services to AlaskaCare employees.[58]
• ***Arizona:*** Medicaid limits remote patient monitoring reimbursement to patients with congestive heart failure and a certain hospitalization history.[59]
• In ***California, Colorado, and Oregon***, Medicaid managed care organizations (MCOs) have voluntarily selected to contract with Project ECHO programs to support effective medication, pain, or chronic disease management.[60]
• ***Illinois:*** Announced by Governor Pritzker on August 15, 2019, Illinois is investing $420 million in broadband infrastructure to stimulate telehealth, education, and economic development in rural areas. Through increased telehealth efforts, Illinois plans to provide additional healthcare options and expanded treatment opportunities (e.g., mental health and opioid addiction) to rural communities.[61]
• ***Kansas:*** Through a HCBS (1915(c)) waiver application, the Frail Elderly waiver provides Kansas seniors nursing home care alternatives and additional services, including home telehealth and nursing evaluation visits. The program can serve as a blueprint for Medicaid-eligible Tennessee seniors over 65 years old that meet the nursing facility threshold score.[62]
• ***Massachusetts:*** A study examined the pre- and post-tele-ICU effects on ICU mortality and ICU length of stay in one academic center and two community hospitals. It found that ICU mortality declined significantly in two hospitals but increased in one of the community hospitals. All three hospitals saw an ICU patient length of stay decrease, and a rapid payback period for financial investments.[63]
• ***Massachusetts:*** Members enrolled in MassHealth, Massachusetts' Medicaid program, can use a virtual care platform to access mental health and substance use services. Behavioral health providers are reimbursed at the same rate as an in-person visit.[64]
• ***Mississippi:*** Mississippi's State Health Insurance Plan expanded access to behavioral health services via telehealth.[65]
• ***Mississippi:*** In 2014, the University of Mississippi Medical Center partnered with a regional high-speed wireless provider to launch a pilot program to bring remote patient monitoring to patients living with Type II diabetes and other chronic conditions in the Mississippi Delta. The remote patient monitoring improved outcomes and reduces costs within the pilot program.[66]

Examples of State and Federal Initiatives[9]

- ***New Mexico:*** Project ECHO has grown significantly since its origins in New Mexico.[67] There are currently 429 Project ECHO programs serving all 50 states. "More than 50 percent of all Project ECHO programs serve rural counties in the United States." A map of all rural and urban counties served by a Project ECHO is below.[68]



- ***U.S. Federal Communications Commission:*** The agency established a new $100 million Connected Care Pilot Program to support telehealth for low-income Americans, including those living in rural areas and veterans.[69]

Theme 3: There are significant healthcare access barriers in rural communities, including the lack of providers.

Rural communities across the nation continually struggle with access issues related to transportation and provider supply. Following the Listening Tour, it was clear that rural communities in Tennessee are no different.

"If rural communities could help relieve student debt in less time – four years versus 15, it would attract people."

- Provider and Research Institution Representative

During the Listening Tour, stakeholders emphasized that:

- Workforce development initiatives are necessary to meet the current and long-term healthcare needs of Tennesseans. Tennessee needs to design not only financial incentives, but also highlight non-financial benefits of living in rural areas (e.g., quality of life).
- Provider supply, recruitment, and retention remains a barrier in rural areas. Tennessee needs to recruit providers, but also recognize that providers will need help recruiting support staff and supplement with telemedicine/telehealth. Providers and their staff also need to consider their families (e.g., jobs for their spouses, school systems).
- Physician recruitment in rural areas is even more challenging because of the financial burden of graduate medical education. Multiple stakeholders noted that administrative burdens of working within a rural area provider also makes physician recruitment more challenging.

Stakeholders also indicated a lack of reliable transportation, which is crucial for rural residents to access healthcare services. In addition, the lack of transportation in rural areas hinders discharge planning and timely discharge efforts, which increases the length of stay for patients and costs. Please note that additional findings and guidance related to transportation are discussed in Theme #1 of this document.

Policy Landscape – Rural Healthcare Access Policies and Programs

National

Health professional shortage areas (HPSAs) are found throughout the United States, and states are exploring methods to address provider shortages by combining financial incentives with legislative or regulatory reforms that expand healthcare access to rural areas. Although many states have tried to expand access, policymakers are often restricted by the scope of practice laws in their states. For example, in primary care, 20 states, including Tennessee, require a physician to co-sign a percentage or number of physician assistant charts to be reimbursed for services.[70] Thirty-nine states, not including Tennessee, limit the number of physician assistants that a physician can supervise or collaborate with, known as ratio requirements.[71]

States have also modified the scope of practice for another key rural health provider, dental hygienists:

- Eighteen states recognize and reimburse dental hygienists as Medicaid providers.[72] In Tennessee, dentists can bill for services provided by hygienists under the supervision of the dentist.
- California and Wisconsin allow hygienists to operate independent practices without the supervision of a dentist in select locations.[73]
- Louisiana, North Dakota, and Alabama prohibit hygienists from having direct patient contact until the patient has seen a dentist.[74]

Physician extenders, such as physician assistants and nurse practitioners, could play a vital role in filling in gaps of coverage. As states continue to face healthcare workforce shortages, states must balance the need for physician extenders with the safety of patients and need for formally trained physicians to deliver services.

On the national stage, Tennessee Senator Marsha Blackburn has introduced three bills focusing on closing medical access gaps in rural communities:

1. The bipartisan Rural America Health Corps Act would improve the existing National Health Service Corps (NHSC) loan repayment program by providing new funding for practitioners that serve in rural communities on a sliding scale, and rotate healthcare graduates through rural areas.[75]
2. The Rural Health Innovation Act would establish two five-year grants. One grant program would help support Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to become capable of meeting a community's urgent care and triage needs. The second grant would expand rural health departments to meet urgent care and triage needs.[76]
3. The Telemedicine Across State Lines Act introduced on July 31, 2019 would establish a national telehealth program and a five-year grant to push telemedicine programs into rural communities.[77]

In the United States House of Representatives, Tennessee Representative Mark Green (TN-7) introduced the Rural Health Care Access Act in May 2019. The proposed Act would remove the mileage limitation that restricts hospitals from gaining Critical Access Hospital designation.[78]

Tennessee

The Tennessee Department of Health supports the Tennessee State Loan Repayment Program (TSLRP) which provides loan repayment to qualified primary care providers in exchange for two years of service at an ambulatory public, nonprofit, or private nonprofit primary care location in a federally designated HPSA.[79] The program has traditionally focused on primary care physicians, dentists, advanced practice nurses, physician assistants, and, as of January 2019, behavioral health professionals including psychiatrists, clinical social workers, and psychiatric nurse specialists.[80]

Recently, the Center for Rural Health Research (the Center) was established at the East Tennessee State University (ETSU). The public-private partnership will work with Ballad Health

(a large healthcare provider), local healthcare delivery partners, national experts, and the leadership of ETSU to identify new mechanisms to improve health in rural and non-urban communities. The Center will have a specific emphasis on strategies that disrupt inter-generational cycles of behaviors that contribute to poor health outcomes, which ultimately can affect college and career readiness.

Access to Healthcare and Provider Capacity – National and Tennessee Data

Access to healthcare providers presents a challenge for Tennesseans, particularly those living in rural areas. In Tennessee, many of the counties with undesirable ratios of healthcare providers per capita (i.e., high number of individuals per provider) are located in rural areas of the State. Counties with more favorable ratios of access to healthcare providers per capita (i.e., low number of individuals per provider) are located in more urban or suburban areas of the State, which may be in closer proximity to hospitals and other healthcare facilities. National survey data suggests the following barriers for rural residents: affordability, distance to providers, and provider capacity.

National

Individuals living in rural and urban communities are limited by access to providers and provider capacity. As shown in Figures 18 and 19, in a 2019 survey, "Life in Rural America – Part II," approximately one-quarter of rural residents needed healthcare but did not get it.[81] Among those who did not get care, affordability was the primary reason for forgoing care, followed by difficulty getting to the location and inability to schedule an appointment during available hours.

Figure 18: Approximately One-Quarter of Rural Americans Cannot Access Care When Needed[82]

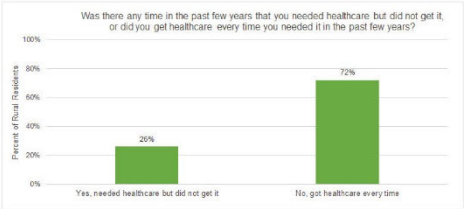
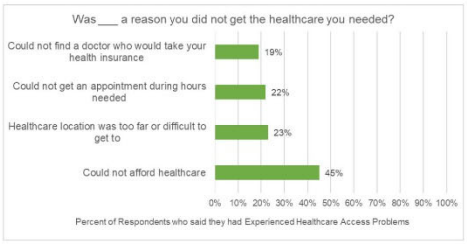


Figure 19: Affordability Is a Common Barrier for Individuals Seeking Care[83]



Tennessee

Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute issue annual County Health Rankings to provide information on vital health factors. This resource ranks counties within each state to "raise awareness about the many factors that influence health and that health varies from place to place."[84] Using the County Health Rankings Data[85], we assessed three measures of access to healthcare providers:

1. The ratio of the population in a county to dentists,
2. The ratio of the population in a county to mental health providers, and
3. The ratio of the population in a county to primary care physicians.

The Tennessee rankings for the three access to health measures are depicted in the maps in Figures 20, 21, and 22.

Figure 20: Ratio of Population to Dentists[86]

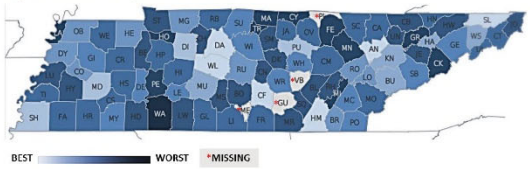


Figure 21: Ratio of Population to Mental Health Providers[87]

Figure 22: Ratio of Population to Primary Care Physicians[88]

Per Figures 20, 21, and 22, the following counties stand out for having desirable ratios in multiple provider categories – for example:

- *All three provider categories:* Davidson, Hamilton, and Madison counties
- *Two out of three provider categories:* Coffee, Hamblen, Henry, Knox, Maury, Putnam, Shelby, Sullivan, Washington, and Williamson counties

However, several counties have less desirable ratios in multiple provider categories – for example:

- *All three provider categories:* Macon and Morgan counties
- *Two out of three provider categories:* Crockett, Grainger, Lake (data is only available for two provider categories), and Meigs counties

These per capita provider ratios indicate a potential gap in access to care for individuals living in these counties. While several counties (e.g., Lake and Meigs) are in rural areas, the remaining counties are adjacent to urban areas.[h] Since the data presented only counts providers with

[h] For the purposes of this analysis, rural is defined as counties outside of the Office of Management and Budget's core-based statistical areas defined as of September 2018 and available at: https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

offices within the actual county, Tennesseans living in these urban-adjacent counties may be traveling to another urban area (e.g., employment center) in another county to access healthcare services.

Figures 23 and 24 highlight the difference in care capacity between Tennessee counties that have at least one hospital and counties that do not have a hospital.[90] Counties that lack hospitals generally have lower primary care and behavioral health capacity than counties with hospitals. Twelve rural Tennessee hospitals have closed since 2005, potentially leaving rural communities with diminished care capacity.[91]

Figure 23: Population to Primary Care Physician Ratio by County Is Higher in Counties Without a Hospital, 2016[91]

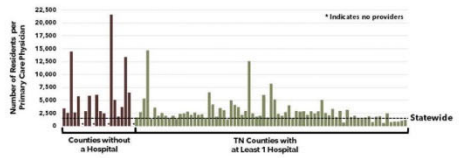
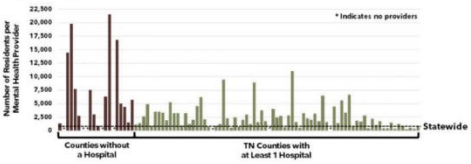


Figure 24: Population to Mental Health Ratio by County Is Higher in Counties Without a Hospital, 2017[92]



Potential Policy Options Related to the Theme #3

In Figure 25, we have identified two potential policy options for consideration to address healthcare access barriers in rural communities:

Figure 25: Potential Policy Options to Address Healthcare Access in Rural Areas

Policy Option	Rationale for Policy Option
1. *Expand healthcare workforce development programs and initiatives*	Rural communities across Tennessee are having difficulty maintaining a sufficient healthcare workforce through recruitment and retention, resulting in decreased access to patient care and insufficient staffing standards for optimal provider operation. In addition, Tennessee's scope of practice regulations may prohibit some professionals from working to the top of their license.
2. *Expand capacity of the existing healthcare workforce*	

Examples of State and Federal Initiatives

Figure 26 below details a sample of current state and Federal initiatives related to workforce development in rural areas. This table is not an exhaustive list of current initiatives.

Figure 26: Examples of State and Federal Initiatives

Examples of State and Federal Initiatives[i]
• ***California:*** CalHealthCares is a new program to help physicians pay back up to $300,000 of medical school debt in exchange for dedicating one-third of their caseload to Medi-Cal. California's Medicaid program, patients for five years. The program will disburse a total of $340 million and its first round of awardees will benefit 247 physicians and 40 dentists. The State hopes the program will help address California's 4,700 primary care physician shortfall projected by 2025, which greatly impacts the Medi-Cal population and rural communities.[93]
• ***New Mexico:*** In April 1993, the Legislature of the State of New Mexico enacted the Pharmacist Prescriptive Authority Act, which granted authority to pharmacist clinicians for prescribing medications. Pharmacist clinicians are pharmacists with additional training required by New Mexico regulation.[94]
• ***Rhode Island:*** The State passed legislation in July 2019 that would allow physician assistants to work collaboratively with physicians rather than under their supervision, giving them additional freedom and allowing them to see more patients. Additionally, doctors are no longer liable for a physician assistant's work within their practice, but they must always be accessible.[95]
• ***International Association of Chiefs of Police (IACP) and the Childhood Violence Trauma Center at the Child Study Center at the Yale School of Medicine:*** The IACP and Yale School of Medicine, supported by funding from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, implemented a program to increase the capacity of law enforcement to identify and respond to child exposure to violence and childhood trauma. The initiative includes toolkits, classroom and online training programs, and webinars.[96]

[i] This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Examples of State and Federal Initiatives[1]

- ***National Nurse Practitioner Practice Authority:*** Several rural states have changed scope of practice laws to allow physician extenders to practice more independently. Nurse practitioners, for example, have full practice authority in 23 states as seen in the map below.[97]

Several Rural States Have Expanded Nurse Practitioner Scope of Practice to Address Healthcare Workforce Shortages[98]

Full Practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

Reduced Practice: State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

Restricted Practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

- Medical schools, including the ***University of California – San Francisco*** (UCSF), have developed specialized rural health tracks that promote the appeal of rural life.[99] UCSF's San Joaquin Valley PRIME program is a tailored medical education track for students who commit to spending 1.5 years at the UCSF campus, and 2.5 years clinical training at the UCSF Fresno campus.[100]

Theme 4: Social determinants of health will be important to address.

When providing treatment and care, it is essential to consider social determinants of health such as housing, income, transportation, food security, employment/workforce development, education, childhood experiences, behavior, access to care, and environment. Panelists referenced that social determinants accounted for a significant percentage of a patient's health outcomes, and the literature indicates that these determinants can account for up to 80 percent of a patient's health outcomes.[101] With the transition from fee-for-service to value- and outcome-based care, it is becoming more and more essential for policymakers across the nation, and in Tennessee, to recognize the critical role that social determinants play when providing whole-person care.

> *"When we think about how to prevent chronic conditions, we can't ignore that 10 percent is due to healthcare and the main factors are behavior and zip code."*
> *- Provider and Research Institution Representative*

Stakeholders also believe that Tennessee agencies, providers, and payers will need to work together to address social determinants of health that create gaps in care. There are existing initiatives (e.g., Building Strong Brains: Tennessee Adverse Childhood Experiences (ACEs) Initiative, Tennessee Recovery Navigators, Lifeline Peer Project) that, with the right level of education and involvement across the State agencies, could help improve healthcare across the State.

Policy Landscape – Social Determinants of Health Policies and Programs

National

States, the private sector, and the Federal government continue to consider and implement various programs to address social determinants of health. For example:

- **States:** Given that Medicaid is a large component of state budgets, states continue to innovate by addressing social determinants, aiming to comprehensively address healthcare outcomes and access. As a result, states have used multiple tools at their disposal to uniquely address social determinants:
  - Seventeen states, including Tennessee, are using Medicaid managed care contracts, and six states (Hawaii, Maryland, New York, North Carolina, Rhode Island, and Washington) are using Medicaid Section 1115 demonstration waivers to cover housing-related services.[102] North Carolina is using the Section 1115 demonstration waiver authority to implement Health Opportunities Pilots within their managed care system. The pilots will integrate non-medical SDoH services, such as food or transportation into healthcare delivery services.[103]
  - Thirty-five states now require or encourage Medicaid MCOs to screen enrollees for social issues and provide referrals to services. North Carolina and Rhode Island specifically require MCOs to track referral outcomes and provide additional help to MCO members as needed.[104]

- **Private Sector:** Companies such as CVS Health and Aetna have recently invested more than $40 million in affordable housing, and will collaborate with Unite Us, a social care coordination platform, to further address social determinants of health.[105] Anthem also launched a "social determinants of health benefits package" for seniors enrolled in its Medicare Advantage plan, and UnitedHealthcare has invested over $400 million in new affordable housing communities across the country.[106,107]

> *Social determinants of health are "the root cause of so much of our health spending."*
>
> *- Alex M. Azar II*
> *Secretary, United States Health and Human Services*

- **Federal Government:** A bipartisan group of representatives introduced the Social Determinants Accelerator Act in July 2019.[108] The Act makes up to $25 million in grants available to state, local, and Tribal governments to develop Social Determinants Accelerator Plans that, among other goals, include a plan to link data across programs to achieve better outcomes through health and non-health service coordination. The Act also calls for the formation of a technical advisory board that includes experts from state and local governments, private and community-based organizations, and across the federal government, including the Department of Labor, the Department of Agriculture, and Department of Housing and Urban Development (HUD).[109] In addition, the Department of Health and Human Services is encouraging states and health plans to participate in new models of care designed to address social determinants of health. These models include Accountable Health Communities, Maternal Opioid Misuse, and Integrated Care for Kids.[110]

Tennessee

Social determinants are addressed by several governmental agencies within the State, including the Department of Transportation, the Department of Health, and the State's Department of Labor and Workforce Development. Tennessee's Department of Health offers a wide scope of program areas related to social determinants of health, such as healthy homes (a comprehensive approach to preventing diseases and injuries that result from housing-related hazards and deficiencies), farmers market nutrition programs, and Project Diabetes.[111] The State's Department of Labor and Workforce Development manages several initiatives through the Workforce Innovation and Opportunity Act, including Eligible Training Provider List, Senior Community Service Employment Program, Jobs for Veterans State Grant Program, and Re-Employment Services and Eligibility Assessment.[112]

In addition to operating the Section 1115 demonstration waiver that governs TennCare, Tennessee also operates several 1915(c) Home- and Community-based Services (HCBS) waivers, including the Self-Determination Waiver Program which serves children and adults with intellectual disabilities and children under the age of six with developmental delays who would otherwise qualify for and require placement in a private intermediate care facility for individuals with intellectual disabilities. Under the waiver, enrollees have access to services that support integration into the community and address social determinants that greatly impact the enrollee's ability to remain independent. The waiver program provides employment services,

supported employment for individuals and small groups, nutritional services, transportation services, and environmental accessibility modifications.[113,114]

Social Determinants of Health – National and Tennessee Data

Trends in social determinants of health and the prevalence of chronic conditions across the State suggest that initiatives to address health outcomes will need to be tailored based on county characteristics.

Tennessee

Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute issue annual County Health Rankings to provide information on vital health factors. This resource ranks counties within each state to "raise awareness about the many factors that influence health and that health varies from place to place."[115] Using the County Health Rankings Data[116], we reviewed measures to assess social and economic factors, as well as individual health behaviors that influence the health of individuals and communities, such as obesity and smoking.

Figure 27: High School Graduation Rates in Tennessee[117]

Higher educational attainment is associated with better physical and self-reported health. The overall four-year high school graduation rate in Tennessee is 90 percent, ranging from 80 percent in the poorest performing counties to 100 percent in the highest performing counties. Urban counties such as Davidson County and Shelby County have the lowest high school graduation rates within four years.

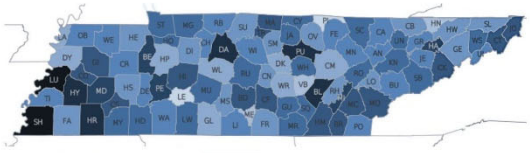
Figure 28: Eastern and Western Edges of Tennessee Face Food Insecurity[118]

BEST — WORST *MISSING

Another social determinant of health measure is the Food Environment Index, which is an indicator of access to healthy foods. The index ranges from 0, the worst, to 10, the best. This index equally accounts for proximity to a grocery store or supermarket and the percentage of the population facing food insecurity. Across Tennessee, the average Food Environment Index is 6.3, ranging from 5.3 in the poorest performing counties to 9.2 in the highest performing counties. The eastern and western edges of Tennessee have the lowest Food Environment Index scores, whereas the middle area of the State tends to score higher.

In addition, food insecurity challenges affect both rural and urban areas of the State. The counties with the lowest Food Environment Index scores include a mix of metropolitan (e.g., Shelby, Carter), micropolitan (e.g., Haywood), and rural (e.g., Lauderdale, Hardeman) counties.

Figure 29: County Health Rankings Indicate Several Counties Face Severe Housing Problems[119]



BEST — WORST *MISSING

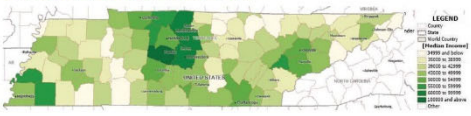
Adequate and safe housing is associated with positive health outcomes. The Severe Housing Problems factor measures the percentage of households that have one or more of the following problems: lacks complete kitchen facilities, lacks complete plumbing facilities, is overcrowded, is severely cost burdened. Overcrowding and severe housing cost burden (i.e., monthly housing costs, including utilities, exceed 50 percent of monthly income) drive the high rates of severe housing problems. Housing issues affect both rural and urban areas of the State; rural counties, such as Bledsoe and Lauderdale, and urban counties, such as Davidson and Shelby, rank among the most unfavorably within Tennessee.

As seen in Figure 30, Tennessee falls below the United States average for median household income. Only eight counties exceeded this average in 2017. The five counties with the lowest incomes had median household incomes below $32,000.

Figure 30: Tennessee County Rankings by Median Household Income, 2017[i, 120]

Generally, median household income is highest in major cities and their surrounding areas.

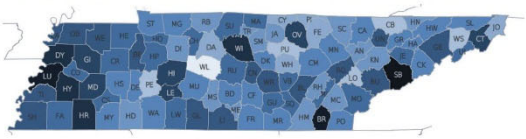
Figure 31: Median Household Income, 2017[121]



In addition to social and economic factors, individual health behaviors influence the health of individuals and communities. In Figures 32 and 33 below, we use the County Health Rankings Data to identify trends in key risk factors, including adult obesity and adult smoking.

[i] Comparison Southeastern states include Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, and South Carolina.

Figure 32: Tennessee's Adult Obesity Prevalence Is Above the National Average[122]



BEST — WORST *MISSING

Obesity prevalence is defined as the percentage of adults that report a body mass index (BMI) greater than or equal to 30. The overall obesity rate in Tennessee is 33 percent, ranging from 39 percent in the poorest performing counties to 25 percent in the highest performing counties. Thirty-one counties perform above the national average, which is 32 percent.[123] Only one county, Williamson, scores within the highest performing 10 percent of counties nationally.

Figure 33: Smoking Prevalence Is Above the National Average Across Tennessee Except for One County[124]

BEST — WORST *MISSING

Smoking prevalence (or the percentage of adults that reported currently smoking) is a notable risk factor for the State. The average percentage of smokers across all Tennessee counties is 22 percent, with percentages ranging from 27 percent in the poorest performing counties to 15 percent in the highest performing counties. Only two counties in Tennessee, Loudon and Williamson, perform equal to or better than the national average of 18 percent.[125]

Potential Policy Options Related to the Theme #4

In Figure 34, we have identified two potential policy options to focus on initiatives that address social determinants of health.

Figure 34: Potential Policy Options to Address Social Determinants of Health

Policy Option	Rationale for Policy Option
1. *Align state, private, and public entities to comprehensively address a social determinant*	Social determinants such as housing, education, socioeconomic status, employment/workforce development, and access to care can largely be improved through partnerships between local, state, and federal agencies and private organizations.
2. *Promote awareness of and action on social determinants and comprehensive care approaches*	While it is important to focus on developing and implementing initiatives related to social determinants of health, it is equally important to make patients, providers, and payers aware of the initiatives and provide appropriate education on comprehensive care approaches.

Examples of State and Federal Initiatives

Figure 35 below details a sample of current state and Federal initiatives related to social determinants of health. This table is not an exhaustive list of current initiatives.

Figure 35: Examples of State and Federal Initiatives

Examples of State and Federal Initiatives[k]
• ***Tennessee Health Care Innovation Initiative:*** As part of the Tennessee Health Care Innovation Initiative, TennCare established the Patient Centered Medical Home (PCMH) & Health Link programs. Both programs focus on primary care transformation and promote the delivery of preventive services and the management of chronic illnesses over time. These programs have a large emphasis on the coordination of physical and behavioral health and offer incentives to providers through performance outcome payments that encourage adherence to performance improvement.[126]
• ***California:*** The Medically Tailored Meals Intervention program is a three-year, $6 million project funding six nonprofits in eight counties. The nonprofits deliver three medically tailored daily meals for 12 weeks to Medi-Cal beneficiaries with ongoing congestive heart failure. The results of the program so far indicate reduced readmission rates and hospitalizations.[127]
• ***Colorado:*** Through a collaborative effort between Reach Out and Read Colorado, the Colorado Governor's Office, and the Colorado Department of Public Health and Environment, 200,000 books are "prescribed" annually by approximately 330 clinics and 1,700 healthcare professionals. These books reach 125,000 children between the ages of six months and five years old in 62 out of 64 Colorado counties. Studies show that children's language development in such programs improve within three to six months.[128]
• ***Maryland:*** The Maryland Governor's Office for Children collaborated with a national nonprofit, Share our Strength, to introduce the Partnership to End Childhood Hunger. The Partnership aims to connect eligible children and families to federal nutrition programs, such as the School Breakfast and Summer Food Service Programs.[129]

[k] This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Examples of State and Federal Initiatives[k]
• ***New York:*** The Medicaid Redesign Team (MRT) Supportive Housing Initiative provides funding for rental subsidies, support services, and capital projects. The Initiative serves multiple populations through many partnerships with entities, including the Department of Health's Office of Health Insurance Programs and the Office for People with Developmental Disabilities. Over 13,000 high acuity Medicaid patients have been served since 2012, resulting in a 40 percent reduction in inpatient stays, 26 percent reduction in emergency department visits, and a 15 percent reduction in overall Medicaid health expenditures post-enrollment. As of September 2017, the Initiative had developed 19 rental subsidy and supportive services programs statewide.[130,131]
• ***North Carolina:*** NCCARE360 is an electronic coordinated care network that enables providers to send and receive electronic referrals and share resource data with community partners. Through the online platform, providers can refer patients to nonmedical services including healthy food, safe and affordable housing, and employment programs. The platform also serves as a data repository that monitors accountability, service delivery, and closes the loop on completed referrals.[132]
• ***Oregon:*** The Act to End Hunger began in 2004 and was extended for another five years in 2009. The Act involved a significant outreach program, established a state food policy council, and increased the number of vendors that accept Supplemental Nutrition Assistance Program (SNAP). Program participation increased SNAP participation to 80 percent among eligible people and brought over $1 billion a year to Oregon's economy.[133]
• ***Pennsylvania:*** The Governor, along with various other departments, formed the Governor's Food Security Partnership. The Partnership promotes coordination, communication, and joint planning between public and private sector entities to provide nutrition and food assistance to residents. The Governor also proposed increasing cash grants to counties to purchase and distribute food to low-income individuals.[134]
• ***Texas:*** The BookSpring Read\Well program supports pediatric literacy through partnerships between providers and parents with children up to the age of six to develop critical reading skills. This program is restricted to clinics for low-income populations in central Texas, consisting mainly of families on Children's Health Insurance Program (CHIP), Women, Infants, and Children (WIC), Medicaid, or who have no insurance. Financial support comes from the United Way of Greater Austin, and other organizations. ReadWell serves over 20,000 children annually.[135]
• ***Medicaid Case Management Programs:*** 36 states, including Tennessee, currently provide targeted case management as a Medicaid State Plan benefit. Certain programs involve cost-sharing (e.g., Georgia requires a $3 copay), and other programs have service limits (e.g., Arizona limits its program to the Developmental Disabilities population and Delaware to pregnant women with prior authorization).[136]
• ***Medicaid Health Homes (Section 2703):*** All states have an opportunity to obtain 90 percent Federal match funding to develop Medicaid "health homes" for patients who have chronic conditions. The law defines these as teams of "primary care clinicians, nurse practitioners, or physician assistants who work with other healthcare professionals to provide comprehensive care management, care coordination and health promotion, transitional care between hospital and primary care, referral to community and social services, patient and family engagement, and use of IT to link services."[137]
• ***Northwell Health's Social Health Alliance to Promote Equity (SHAPE) program:*** This program was developed to address social determinants of health in clinical practice by screening patients across multiple social categories. At two internal medicine and pediatric primary care clinics at Northwell Health in New York, facility-based patient navigators screen for and address patient needs through a referral process. Navigators assist physicians with referrals to child care, hunger and homeless services, and legal services.[138]

Examples of State and Federal Initiatives[k]
• ***Sutter Health Advanced Illness Management (AIM) Program:*** This initiative positions registered nurses or social workers in hospital, community, and tele-support settings to assess the clinical and social needs of patients with terminal conditions and limited prognoses and help them navigate physical and emotional challenges.[139]
• ***UnitedHealthcare and American Medical Association:*** The American Medical Association and UnitedHealthcare are collaborating to support 20 new International Classification of Diseases (ICD)-10 codes related to social determinants of health. The codes aim to more effectively address nonmedical issues, such as food, housing, transportation, and the ability to afford medicine, utilities, and other services.[140]

Theme 5: Greater transparency in healthcare may improve patient outcomes and experiences.

Price transparency is an issue receiving national and statewide attention. Several public and private tools are available through government entities and payers to assist consumers in making cost effective healthcare choices. For most goods and services, consumers can shop around, compare prices, and select the best product that fits their needs and budget. In healthcare, consumers are undereducated about the product they are buying and the appropriate price to pay for the product. This has led many leaders in the healthcare industry and government to support price transparency initiatives.

> *"The average person doesn't comprehend the concept that there is absolutely no rhyme or reason to what a provider can bill. There's no regulation and there's no barometer in any sense."*
>
> - *Payer Representative*

Surprise billing (i.e., balance billing) can be the result of a specific market failure when hospital-based providers can bill patients directly for their services, and is another issue receiving national and statewide attention. In some cases, including in rural areas, provider groups contract with hospitals to deliver necessary ancillary services, but are not considered hospital employees and, therefore, are out-of-network. Patients are often unaware of these arrangements and do not have a choice in provider, resulting in a "surprise bill" after services are provided.

Several states are attempting to address surprise billing through legislation, regulation, and contracting standards to decrease the likelihood of placing additional financial pressure on consumers. However, the most effective policy may require federal action to address self-funded plans that are exempt from state insurance requirements.

During the surprise billing and price transparency Listening Tour, multiple panelists emphasized the need for useful pricing data that connects the provider, price, and related quality outcomes. The panelists indicated that making pricing data publicly available will not be enough to engage consumers in a meaningful way. Consumers must be educated about what they are buying and have an "anchor" to establish a comparison.

Policy Landscape – Price Transparency and Surprise Billing Policies and Programs

National

There is significant interest and activity at the national level to improve price transparency and reduce surprise billing, as shown in Figure 36.

Figure 36: Examples of Initiatives to Address Price Transparency and Surprise Billing

Organization	Description of Initiatives
Executive Branch	• President Trump has signed executive orders and used the administration's executive powers to advance its drug pricing and transparency efforts. However, on July 8, 2019, the U.S. District Court for Washington D.C. blocked the administration's new rule that requires drug manufacturers to disclose list prices in direct-to-consumer advertisements. The ruling stated that the Department of Health and Human Services (HHS) lacked the authority to impose such a requirement.[141]
U.S. Congress	• There are pending proposals within the Senate and House to address surprise billing including the Lower Health Care Costs Act, sponsored by Tennessee Senator Lamar Alexander, the STOP Surprise Medical Bills Act, and the No Surprises Act.[142,143]

States have also introduced price comparison websites that rely on multiple data sources and vary widely in the scope and detailed level of price comparison. Figure 37 compares the states currently using price-comparison websites, their data sources, and functionality.

Figure 37: Recent Price Transparency Vary by States[144]

State | Website | Launched	Type of price	Procedure or bundled price	Searchable services	Price by: Insurer	Medical group	Hospital	Free-standing surgical center
Colorado | **Shop for Care** | 2018	median	both	38	✘	✔	✔	✔
Florida[1] | **Florida Health Price Finder** | 2018	average	bundle	295	✘	✘	✘	✘
Massachusetts | **CompareCare** | 2018	median	procedure	~300	✔	✔	✔	✔
Maryland | **WearTheCost** | 2018	median	bundle	4	✘	✘	✔	✘
Maine | **CompareMaine** | 2015	average	procedure	233	✔	✔	✔	✔
New Hampshire | **NH HealthCost** | 2007	median	both	124	✔	✔	✔	✔
Washington | **WA HealthCareCompare** | 2018	median	procedure	100	✘	✘	✔	✔

[1]Statewide averages per service.
Sources: Freedman HealthCare; New Hampshire Department of Insurance (NH searchable services, excludes dental); Center for Improving Value in Health Care; and other states

Tennessee

In Tennessee, the "Right to Shop" bill passed in 2019, which will create a statewide database that publicizes service prices and includes prices of in-network services.[145] This is similar to price transparency measures taken by several other states.

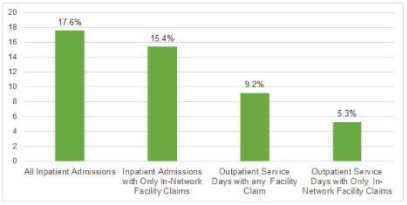
Trends in Out-of-Network and Surprise Billing – National Data

Surprise out-of-network billing and the associated costs to patients have increased in recent years, particularly among inpatient admissions and emergency department visits to in-network hospitals. According to a study from the Journal of American Medicine, out-of-network billing increased from 26.3 percent to 42.0 percent between 2010 and 2016 for privately insured patients.[146] For patients, this meant an average increase in out-of-pocket costs for a given inpatient stay rose from $804 to $2,040, a 154 percent increase.

In another national study, the Kaiser Family Foundation found that among people with large employer coverage, one in five inpatient admissions includes a claim from an out-of-network provider.[147] More than seven percent of patients receiving care in an outpatient setting also received bills including claims from an out-of-network provider.

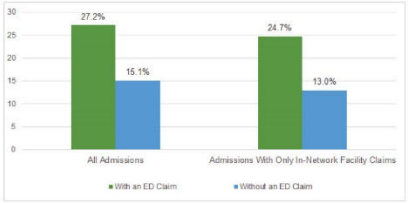
Patients seeking healthcare services at in-network facilities are not necessarily protected from paying out-of-network rates. Figure 38 indicates that even when patients use in-network facilities, they can still be billed by out-of-network providers.

Figure 38: Percentage of Admissions or Outpatient Service Days that include a Claim from a Non-Network Provider, by Service Location and Facility, 2016[148]



The same Kaiser Family Foundation study also considered the reason for admission as part of the analysis. Inpatient admissions for behavioral health conditions, such as substance use treatment, and surgery are associated with higher rates of claims from out-of-network providers.[148] Moreover, a quarter of inpatient admissions that include an emergency department-related claim were found to include claims for an out-of-network provider, as shown in Figure 39.

Figure 39: Percent of Inpatient Admissions Including a Claim from an Out-of-Network Provider by Facility and Emergency Department (ED) Claim[150]



Patients may face high out-of-pocket costs associated with these out-of-network claims, and in cases of emergency, patients often lack choice in which doctor they see or how they are transported to the hospital.

Potential Policy Options Related to the Theme #5

The urgency to address surprise billing stems from the substantial downstream impacts on consumer out-of-pocket costs and finances, as well as physical health. Price transparency has also been highlighted as a potential tool to bend the overall healthcare cost curve. In Figure 40, we have identified three potential policy options for consideration that address surprise billing and price transparency.

Figure 40: Potential Policy Options to Support Surprise Billing and Price Transparency

Policy Option	Rationale for Policy Option
1. *Evaluate policy solutions to address surprise billing*	Eliminating and reducing surprise billing will protect Tennesseans from high-cost bills for emergency and ancillary services and can reduce medical debt and bankruptcy.
2. *Evaluate solutions to help individuals make good healthcare purchasing decisions*	The decision on where to receive healthcare services is not easy to discern. Costs can shift significantly based on deductibles, insurance, in-network, and out-of-network providers. Cost is not associated with quality, and sometimes the best option is unknown to the consumer. Price transparency inclusive of quality benchmarks made available to consumers can help individuals make better decisions and reduce overall healthcare spend.

Policy Option	Rationale for Policy Option
3. *Educate Tennesseans on insurance concepts including deductibles, co-insurance, and premiums*	An educated consumer is a better consumer of healthcare resources which will ultimately drive down the cost of healthcare.

Examples of State and Federal Initiatives

Figure 41 below details a sample of current state and Federal initiatives related to surprise billing and price transparency. This table is not an exhaustive list of current initiatives.

Figure 41: Examples of State and Federal Initiatives

Examples of State and Federal Initiatives[1]
• ***California:*** California adopted Assembly Bill 72 in 2017 that set limits on the amount that can be charged by out-of-network physicians for non-emergency services at in-network hospitals. Patients pay only their in-network cost sharing obligation. Health plans reimburse the out-of-network professionals the greater of the health plan's local average contracted rate or 125 percent of Medicare's fee-for-service rate.[151]
• ***California:*** California Assembly Bill 2708 requires public schools to add information about healthcare coverage to enrollment forms. The State provides schools with educator toolkits to help schools enroll families and children in healthcare coverage.[152]
• ***Massachusetts:*** In 2012, Massachusetts required health insurers to develop online cost estimators, which have become more user-friendly and comprehensive over time. These tools are used by a small fraction of the market and have other limitations, including the lack of cost data on behavioral health procedures.[153]
• ***Minnesota:*** In July and August 2019, two bipartisan laws went into effect that required large hospital systems to post facility fees, and for clinics to disclose the prices of their 25 most common procedures, respectively. The new laws are intended to address out of control healthcare costs by educating the public on procedures.[154]
• ***New Hampshire:*** NH HealthCost is an online service developed in 2007 to compare approximately 120 medical services, including blood tests, emergency room visits, and biopsies, and compare prices by hospital, medical group, and insurance company.[155]
• ***New York:*** New York's surprise billing law limits surprise billing for out-of-network providers in emergency and non-emergency situations. The State provides a state-run arbitration process to determine billing payment but only applies to state-regulated health insurance plans, not including Employee Retirement Income Security Act (ERISA) self-funded plans.[156]
• ***Texas:*** Senate Bill 1264 goes into effect on September 1, 2020 and allows insurance companies and medical providers to enter into arbitration to negotiate a payment. State officials will oversee the arbitration process.[157]
• ***U.S. House Resolution 3502:*** The legislation would prohibit balance billing for surprise out-of-network services and limit consumer cost sharing for standard in-network services. Additionally, the bill proposes an arbitration process to determine payment to out-of-network providers.[158,159]

[1]This report was developed as a review and examination of the Listening Tour and does not necessarily reflect an exhaustive list of existing State resources.

Examples of State and Federal Initiatives[i]

- The ***Office of the President of the United States*** is proposing requiring hospitals to publicly post the standard charge information for services, supplies, or fees billed by the hospital or provided by employees of the hospital.[110]

Section 4 Alignment of Potential Policy Options and Themes

The Listening Tour revealed many successes and opportunities to improve healthcare for Tennesseans. As we consider which themes and potential policy options to prioritize and implement, Tennessee will also need to consider the following:

- County- and community-specific characteristics, and
- Alignment of selected programs and strategies.

Finally, as we consider the various policy options within this document, Tennessee will also need to review any limitations such as available resources, operational support required by State agencies, and budget.

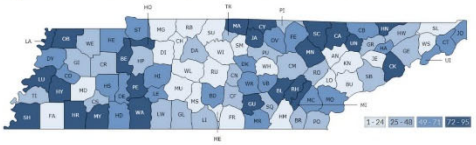
County- and Community-Specific Characteristics

In many cases, communities struggle with multiple healthcare and social determinant challenges simultaneously, such as low provider availability, low rates of vehicle ownership, high rates of adult smoking, and limited access to exercise opportunities. "One size fits all" approaches that fail to account for these unique community circumstances, such as implementing a ride-share program in a county with low vehicle ownership, may not be feasible strategies for these communities. Additional barriers, including geography and economic stability, could hinder a strategy's success. The State will likely need to promote and/or implement strategies tailored to the communities' needs and available resources to make meaningful improvements in healthcare.

To help identify areas of the State where there may be the largest room for improvement, we used County Health Ranking's health factors composite.[h] Figure 42 below shows each county's rank within the State divided into four quartiles with lighter colors indicating better performance. This figure can help the State identify which areas of Tennessee have multiple healthcare-related challenges.

[h] The Health Factors composite calculates a weighted average of the scores for individual measures. Examples of these measures include: (1) Health behaviors (e.g., adult smoking, access to exercise opportunities, food environment index, alcohol-impaired driving deaths); (2) Clinical care (e.g., ratio of primary care physicians, ratio of dentists, flu vaccinations); (3) Social and economic factors (e.g., unemployment, children in poverty, injury deaths); and (4) Physical environment (e.g., drinking water violations, severe housing problems, and long commute – driving alone).

Figure 42: Areas of Similar County Performance Tend to Be Clustered[161]



The western third of the State has almost half of the lowest ranking counties in the health factor composite. Several northern counties (east from Macon to Hancock counties) also have low health factors composite scores. In addition to community-specific approaches, the State may also have an opportunity to work with regional associations and other partners to identify and address regional barriers to healthcare.

Alignment of Potential Policy Options and Themes

Specific strategies the State and its partners may consider to address potential policy options and themes can impact multiple areas. For example, increased leverage of telehealth technologies may also ease transportation challenges and access barriers in rural areas. The State may jointly collaborate on strategies with stakeholders, as appropriate.

To assist the State in its prioritization, Figure 43 outlines opportunities for alignment across the identified potential policy options and themes.

Figure 43: Alignment of Potential Policy Options and Themes

Theme & Potential Policy Options for Consideration	Theme				
	Theme 1 – "Transportation"	Theme 2 – "Technology to Support Chronic Care"	Theme 3 – "Access in Rural Areas"	Theme 4 – "Social Determinants of Health"	Theme 5 – "Transparency in Healthcare"
Theme 1 – Transportation is a significant barrier to care.					
Evaluate public and private options to increase access		✓	✓	✓	
Provide more services at home		✓	✓	✓	
Engage all State agency partners in improving access to healthcare services			✓	✓	

Theme & Potential Policy Options for Consideration	Theme				
	Theme 1 – "Transportation"	Theme 2 – "Technology to Support Chronic Care"	Theme 3 – "Access in Rural Areas"	Theme 4 – "Social Determinants of Health"	Theme 5 – "Transparency in Healthcare"
Theme 2 – Technology, including telehealth, can be a component of the solution to address access issues and a tool for chronic care management, including in rural areas of the State.					
Assess infrastructure to support telehealth			✓		
Leverage telehealth	✓		✓		
Leverage telementoring	✓		✓		
Use telementoring solutions	✓		✓		
Theme 3 – There are significant healthcare access barriers in rural communities, including the lack of providers.					
Expand healthcare workforce development programs		✓		✓	
Expand capacity of the existing healthcare workforce		✓		✓	
Theme 4 – Social determinants of health will be important to address.					
Align state, private, and public entities	✓		✓		
Promote awareness of and action on social determinants of health and comprehensive care	✓		✓		✓
Theme 5 – Greater transparency in healthcare may improve patient outcomes and experiences.					
Evaluate policy solutions to address surprise billing			✓		
Evaluate solutions to support healthcare purchasing				✓	
Educate Tennesseans on insurance concepts				✓	

Section 5 Next Steps

The State will continue to facilitate discussions with agency partners, patients, providers, payers, and other interested stakeholders to improve the health outcomes for Tennesseans. To do this, the State is announcing the Healthcare Modernization Task Force.

Figure 44: Next Steps for Tennessee Healthcare Modernization

Appendix 1 Representative Quotes for Overall Themes[a]

Representative Quotes – Transportation

- "We identified a community within Memphis where there was a lot of infant mortality and a lot of low birth weight babies, and we brought in some people from the Department of Transportation. When they put a bus stop in that community so that those young women [could] get to the doctor, there was a change. So, I bring that up not only because of the success but it definitely shows that sometimes healthcare partners are not those that deal in healthcare every day."

  – *Provider*

- "I think transportation is one of the biggest things and it blocks people from getting the care that they need, the medications that they need, getting physical therapy, everything that you can imagine. They're really just stuck inside that house, and that leads to so many more issues."

  – *Provider*

- "We're finding that sort of over and over that if we can just get people connected to the right spot that many times without necessarily new programs and new dollars that we can improve their health. . . transportation is a big problem in our [community]. And you can see big holes where people just can't get to the doctor's appointments and so on. And so they end up getting emergency transportation to the ER. But I think there's a long way to go with the resources we have."

  – *Provider*

- "Community health is where we see most of our families engaging in healthcare unless they go to an emergency room. And that is not where we want them going. And so really bringing the services to them in their community, where they can access them without barriers to transportation, or without just fear of entering a place that's that big and intimidating. That's something that we had historically been a part of, and that we really encourage."

  – *Community Partner*

- "Even with insurance and an education, I'm not accessing care at that one place where maybe I should be accessing care. I go to where it's convenient. And that's what our families need more than anything."

  – *Community Partner*

[a] The Listening Tour session notes, rather than a recording, served as the primary source material and we indicated these cases with an asterisk (*).

- In regard to crisis services: If you're in Memphis and there's a bed open in Chattanooga, how do you get there? We don't have a way to get a person who has just overdosed into services.*

  – *Provider Association*

- There is a health system out of Minneapolis that created Hitch Health, which is targeted for clinics with high no-show rates. Their product combs through their scheduling data, sends automated text messages to confirm the appointment, and asks if the patient has transportation.*

  – *Commercial Corporation*

Representative Quotes – Technology and Telehealth

- Eventually we will have to lose our grip on the concept of a brick and mortar clinic.*

  – *Provider*

- "We are entering an era where we can create personalized experiences virtually and I think we need to continue to be thoughtful about that."

  – *Provider*

- "I think 11 years ago [regarding] the population we served, I would have told you they don't have a phone, but they do today, and they own a smartphone phone at that. I think looking at technology solutions to . . . get the word out and scale our ability to serve people is important. I think there's some research coming out. . . that shows that technology can make positive improvements in a person's overall health, and then if you add a person on top of that, like care coordination, that creates the individualized touch that's engaging. I think that could be a win-win if you partner the two together."

  – *Provider*

- "We are currently serving prisoners, or incarcerated individuals, through telehealth throughout the State of Tennessee. We're also engaging some of the American Indian tribes and very rural populations in that same way. I think the technology is there. There are still some interoperability challenges around [getting] medical records to talk to each other, but once we solve some of those problems, I think there's going to be a way of reaching individuals."

  – *Provider*

- "We have to get lawmakers to understand that it costs money in the short-term to save money in the long-term. To the extent that we can get lawmakers to invest in supporting the infrastructure so the providers don't have to worry about that; that's going to benefit everybody and save money for everybody."

  – *Provider*

- "Above all else, we are dedicated to improving human life. And telehealth just goes right along with that because telehealth [is] an enabler. [It] allows us a connectivity to provide access to high quality care."

  – *Provider*

- "Believe it or not, there is still a lot of challenge with connectivity. I had one of my neurologists that moved from Hendersonville to Cottontown…and he said 'I'm not sure I can do telemedicine anymore because I can't get a good connection out here. I've tried Sprint, I've tried Verizon, I've tried AT&T.' And so, we were scrambling around trying to figure out what wireless and cellular service is out there. And so, it's still really challenging, and I wouldn't even consider that location a particularly rural area when we compare [it] to some of our other counties in the State. . . . So, anything that the State can do to help support that broadband connectivity, assess where those gaps are, look at our community profiles, those community health assessments and prioritize these spaces where broadband is still a major issue."

  – *Provider*

- "The idea is that all technology surrounding healthcare delivery should share information to improve patient care. Right now, you have medical devices, electronic health records, billing systems that all have proprietary data sets, and hardware that do not share information with the caregivers to provide better care or the patients to know what they're receiving or to tell their next doctor, 'look [at what] I got the last time they went in.'"

  – *Research Institution*

- I need telehealth to work well, from a technological and regulatory standpoint. Telehealth is critical and access to broadband infrastructure is critical to multiple industries, not just healthcare.*

  – *Provider*

Representative Quotes – Barriers to Healthcare Access in Rural Communities and Workforce Development

- "I think a lot of people conflate insurance with access. There are people who are insured who are woefully lacking access, and I think the opposite can be true too. I spent some time in Houston where they had a pretty robust safety net system, and in Denver as well where the uninsured did have pretty decent access. So, I think it is important to understand that you've got to give people access via everyone getting insurance. That's great, but you have to acknowledge that a subset population may never [have insurance], and you need to ensure [access to healthcare] whether it's through a safety net or through community programs."

  – *Payer*

- "It took me nine months to get a pharmacist embedded in one of my clinics. I had to sell it and resell it and resell it and come up with the money. And I will say [an embedded pharmacist] has made such a difference in that one practice's population on medication adherence. That [pharmacist] can talk anybody into anything as far as being compliant with their medicines and understanding them and the providers are so busy.... His value in the clinic is unreal. But to keep his position, I am constantly having to move people and justify his pay. Although he's very valuable, he's not seeing patient's every 15 minutes. It is such a needed resource when you look at this aging population to have that person that they can talk to."

  – *Provider*

- "So, as we may on occasion, ask ourselves, what if we are in the midst of a medical emergency where if we were traveling with a pregnant woman that was in labor, in 20 communities across this State, health or a hospital is not a heartbeat away. These are in communities where hospitals are closed, either recently or in the past. So, having the ability to provide services in these situations has become very critical. In some situations, the next nearest hospital could be more than 25 miles away, can be through mountainous terrain. So, trying to access care in some of these areas can be very challenging."

  – *Provider Association*

- "Our hospitals are the cornerstones of the communities they serve, they're huge economic engines. If you look at our 65 rural hospitals, they have about a billion-dollar economic impact on the communities they serve. Certainly having a community without a community-based healthcare system or hospital, it becomes extremely challenging to recruit business and industry there."

  – *Provider Association*

- "What was really interesting and encouraging for us is the providers that we have placed in our incentive-based program. We have a retention rate of over 80 percent beyond that initial application period. So, most of the providers that we're placing, they're being placed in areas that they have interest in staying long-term."

  – *Provider Association*

- "The biggest thing that I want to say today is Tennessee is the epicenter of rural health closure or rural hospital closures. ... That's big. We may be a little bit behind Texas.... We have lost more per capita than any other state in the nation. Nationally, we have seen over 100 rural hospitals close. This is a crisis that is being felt most prominently here in our State, but it's certainly not without impact to other rural communities in other states. And so, I think that that's why it is imperative that we really focus on 'our why' and come up with a solution that is viable for Tennessee. But it can also hopefully be spread out throughout other areas throughout our nation and the epicenter for a solution."

  – *Provider Association*

- "We have 15 counties that are currently classified as economically distressed. There are an additional 29 counties on top of that, that are at risk. Those are all located in rural areas of our State. In addition, when you look at poverty, our highest rural counties have 84 percent poverty. And that's not just a few, that's actually quite a few that are very impoverished."

  – *Provider Association*

- "One of the best ways to recruit to rural areas is to have people come back home, in their home areas. So, let that inform us about how to identify and incentivize people from rural areas to come back and practice there because they are more likely to stay."

  – *Tennessee State Government Agency*

- "Being a physician is not the only way to practice healthcare. And I think our State has certainly been one of the leaders in the past and coming up in particular with things like nurse practitioners, advanced nurse practitioners, and PAs. And I think, given the competition, we're going to have to continue to look at those ways and continue to help young people see . . . there are other ways to practice medicine, to have that fulfilled life."

  – *Provider and Research Institution*

- If rural communities could help relieve student debt in less time - four years vs. 15, it would attract people."

  – *Provider and Research Institution*

- "What kind of message are we sending to people, when we say we want [direct support staff] to come work in this field, however, we feel your value of work is less than that of your favorite barista? So we strike and we fought to get the rates up to where we can pay direct support staff a living wage. We're at $10 an hour. We appreciate all the support we've gotten on that, but we still have a long way to go."

  – *Provider Association*

- "There's a nursing shortage, the average age of a nurse is over 50. And they'll be exiting the field much quicker than people can come in. So now we have a supply and demand issue. The supply is low, the demand is high, which increased provider calls, which aren't substantiated by rates. So they may end up in almost this point of a lack of access, because we can't compete to get the staffing that we need to provide the services."

  – *Provider Association*

- "We also have aging caregivers. I see more and more people in their 50s and 60s be supported by parents in their 80s, who quite honestly, many, many years ago probably never expected that they would outlive their child. And they haven't made plans. They haven't made preparations."

  – *Provider Association*

- "For example, I have to do this with Johnny, because this is who pays for Johnny's services. But for the exact same thing, I have to do [it] a little differently for Susie because somebody else pays for Susie's services. So anytime we can streamline those types of training and reforms, it's more beneficial to the person supported. I recognize that we have finite resources. And again, if we focused on the efficiencies, and we've reduced the redundancies, we're saving money for the State. We're saving money for providers, and ultimately increasing access."

  – *Provider Association*

- "The psychiatric shortage is a big issue for us. We have extended our use of nurse practitioners and we are heavily reliant on our nurse practitioners but, obviously, nurse practitioners have to be under the supervision of a physician to provide those services so that is a constant challenge for us."

  – *Provider*

- "It became clear that as our population's actually declining over the past five years, and as our admissions were declining, and our population was getting older, and the payer mix was changing, that we weren't going to be able to continue to do the same things that we had done in the past. And we decided that maybe we should stop fighting each other and start worrying more about improving the community's health, that includes trying to keep open a lot of the rural health facilities in the region that simply were not sustainable."

  – *Provider*

- "A third of our hospitals in that area were in danger of closing. We had a closure in the past few years when we were unmerged, and it's obvious why. We have a market where we've got three hospitals in a county of 40,000 people, one that's 15 percent full, one that's 17 percent full, one that's 20 percent full. And so, the boards of the organizations came together and went to the states and asked for a very special solution known as a certificate of public advantage to try to bring these systems together. And the whole purpose of that merger was really to change the model of healthcare in the region, to instead of worrying about putting heads in beds, we were going to be more worried about creating community health and improvement."

  – *Provider*

- Getting people connected to a regular source of care has the strongest effect. ... When you connect with vulnerable populations, you have to do as much as you can when they are in front of you because you don't know when you will see them again."

  – *Provider*

- As we do a better job with educating the community and reducing the stigma about mental health issues, we see more people in need of care. What concerns me long-term

– we will hit a brick wall, where we don't have enough providers, and some would say we are already there."

  – *Provider Association*

Representative Quotes – Social Determinants of Health

- "Our children['s health] is not getting better. We are seeing a decline. And there's an increase in obesity. I was talking to one of the people that was a former chair of our board ...and she is a coordinated school health professional. She said that this year is the very first year that she is seeing children heading into kindergarten, that over 30 percent of her incoming class is classified as obese coming into kindergarten. So that is just frightening and profound. But I believe that our food deserts and our lack of access [to healthy foods] is a huge part of that. So, we have to come around those communities with a solution to get an increase in access to healthy foods, but then also to increase of knowledge of how to prepare healthy foods."

  – *Provider Association*

- "Beginning to break down those walls and force discussions and sort of collisions and interactions from non-traditional stakeholders who absolutely need to have a seat at the table I think will begin to promote the things we all know matter, but really, it's all about alignment and I don't think that's happened well today."

  – *Payer*

- "We know the list of social determinants of health, but I think you have to go to the community. If you're looking to make an impact on this focus group because you can have the data that tells you to go a certain way but if that's not their value and if that's not what they see as their issue, it'll never work....Letting the community tell you what their issue is I think is huge."

  – *Provider*

- "We're beginning to find out that collaboration and a coordinated care plan is probably the magic key to keeping people out of the hospitals and giving them hope in their lives."

  – *Consumer Association*

- "Education is a strong predictor of health. [For] men and women, there is a five to seven-year difference in life expectancy between someone who hasn't finished high school and someone who has finished college. And what that tells you is if you care about improving health as I do, we're not going to be successful in Tennessee until we start getting more people through K-12 system, community college, universities and so on."

  – *Provider and Research Institution*

- Probably the most important thing I've learned in the last 13 years is if we want to improve healthcare, we're going to have to change behavior, and we also have to

reduce poverty through jobs and education. The key is you cannot achieve any one of those three without the other two. We will not improve our health in Tennessee if we don't have education. We can't improve our education if we don't have healthy teachers – it's all interrelated."

– *Provider and Research Institution*

- "We do still have a very high rate of smoking . . . . Currently, we have a law that is called pre-emption. This was passed in 1994, and what it says is the tobacco laws that were in place at that time could not be changed. You in state government are the only ones who can change them. Local government cannot change them. So, what does that mean? Well, it means that you're going to have a really hard time, if you [are] in local government, every year at the state legislature, we have legislators that come and say, "You know I have a park, and we don't want people to smoke there, because we are trying to encourage people to exercise, get their kids out and be in the fresh air. But if you're in any city in this State, you can't really put out that sign that says, "Don't smoke." You can say, "Please don't smoke, it's not courteous" but "don't smoke" is illegal, because of this law. Because of this law, we can't touch any of the licensing or promotion or display of tobacco products. That hurts us."

  – *State Legislator*

- "Not everybody has a place to exercise, and so if we are trying to helping local governments do what they do in providing opportunities for people to exercise and making sure that it's a smoke-free environment, not only do we protect people from second-hand smoke, but the big reason for doing that is that it moves the needle on what is the social norm. As long as people think that it's ok to smoke everywhere, kids see that."

  – *State Legislator*

- "Being healthy is not the absence of disease. It's much more than that. It has to do with your mental well-being, social well-being. As you've heard, healthcare only accounts for ten percent of being healthy. As a matter of fact, there are some organizations that believe that number should be more like five percent. The really major factors in determining how healthy you are your ZIP code and your behaviors. In fact, there are some parts of the country where your ZIP code is the best predictor of your health status. That includes some counties in the State of Tennessee. And we need to accept that fact and act on it if we're going to improve the health of our citizens."

  – *Provider*

- "There's no patient that thinks that their life is inpatient or outpatient, they just live their life across the continuum. And that's what they do. And we need to think about patients in that way."

  – *Provider*

- "Third-grade reading is one of the best predictors of health in the region. And so instead of spending all that money on failing hospitals, where we're fighting each other, we said, 'okay, let's actually start to work together under this merger, and start to redirect these dollars into things that the community actually needs.'"

  – *Provider*

- "It's amazing how many people are just not connecting with services that exist right now, in order to help them out. We've done such a bad job of taking ownership of this and putting the tools in place to connect them. Just one example are navigators. A high-risk female patient indicated that her family had high food insecurity risk, they were running out of money for food the third week every month. And so, in conversations with the navigator, the navigator found out that she was spending $400 out of pocket a month on her insulin and other drugs to treat her diabetes. And so, she got her connected into prescription drug assistance programs and so on, wiped out that $400 expenditure, now she's got $400 extra month to spend on food. We didn't have to create a new program. Those are existing programs. And we're finding that over and over. That if we can just get people connected to the right spot that many times, without necessarily new programs and new dollars, that we can improve their health."

  – *Provider*

- "I will mention, research shows that homelessness drives healthcare costs. 5 percent of patients make up 50 percent of our healthcare costs. And of those 5 percent, all of them are either considered living at the poverty level or unstably housed. So, if we can get at homelessness, and if we can start to solve for that problem, we might have a lot more money available in healthcare, to address some other needs. Boston Medical Center recently launched an initiative where they're partnering with state and local entities. They're investing $6.5 million in this initiative, and it's really focused on affordable housing. But what they found when they started looking at the numbers of healthcare costs for their company, 3 percent of their patients were making up 40 percent of the cost. So pretty consistent with national averages."

  – *Community Partner*

- "And we look at addressing their education, employment, of course, housing needs, and then we also look at social capital and what type of connections and supports they have within the community that are going to strengthen them and give them some opportunities that they maybe haven't had in the past. So, we advocate as United Way, in bringing multiple service providers together to coordinate care. And we know, based on what we've seen with our clients, that it really does accelerate the success of the clients. . . . This starts with navigation. But it also allows a family coach or a case manager to hold the hand of the family member and really walk with them through whatever it is they're doing. When I talked about this, and I tell people some of things we offer, they kind of think, 'Well, there's no way we could do that for everybody.' But we will pay for a person to go back to school and earn their bachelor's degree. We will pay for a

person to earn a GED so that then they have other options to think about whether it's a certification or something like that. What you have to be able to do while you're doing that is also pay for their living expenses. Because I don't know about you guys, but if I quit my job tomorrow to go back to school, someone would have to pay the mortgage, and someone would have to buy the food. And so, it's not as easy as saying, 'Hey, go back to school.' Well, that's great, most people don't have that opportunity. So, we not only help them find the path back to school, but we also support them during that journey to make sure that they have every support in place that's going to help them be successful."

– *Community Partner*

- "Benefit cliff hinders a family's ability to move out of poverty. We can talk about moving families out of poverty for the next 20 years, but if we don't find a way to close the gap with the benefits cliff, we're never actually going to make it happen. A family making less than $7.25 [an hour], is eligible for a lot of benefits. The minute they make $7.25 [an hour], they start to lose benefits that are essential to their families functioning, they don't actually make up that gap until they're making $15 [an hour] or more. And so that's a huge gap. And a minimum wage worker with little to no experience or education, it's going to be hard for them to be making more than $15 an hour, especially quickly. So being able to still figure out how we can close that gap and support families as they move up that trajectory is really important."

  – *Community Partner*

- "We're in an agricultural state. Why in the world when we have produce across Tennessee, in every single county being grown, is it impossible or difficult for patients with little or no income to access fresh produce? That's illogical to me."

  – *Provider*

- "I would say it's not directly healthcare that seems to be the main problem we all focused on. We talked a lot about food, we talked a lot about education, we talked about homelessness, and other things that are these indicators of a lack of health later on. It just seems like there's a big opportunity to lean on data as it's something that's becoming more and more available to us as a state, as a society, to track what are my highest indicators of poor health outcomes and how can I attack those things in a more preventative way, instead of allowing it to become a problem and having to deal with a bigger task later on."

  – *Community Partner*

- "It has been proven that it takes five generations to get out of the cycle of poverty."

  – *Provider and Research Institution*

- "Commissioner Barnes has really started looking at the two generational approach. What that means is when you used to come into our offices, we would sign you up for SNAP,

which is what a lot of you think of food stamps, and we'd send you on your way. Well, now you're going to come in and we're going to ask more questions. We're going to see, can we get you to college? Can we use some of these resources that the State has to really break those cycles of poverty and look at the whole family instead of just the one person who's coming into our office?"

– *Tennessee State Government Agency*

- We have to take a much more holistic approach to the person and to the family. When you are looking at behavioral factors and social factors making up 55 to 60 percent of a perfect person's health condition, that can't be ignored."

  – *Tennessee State Government Agency*

Representative Quotes – Surprise Billing, Price Transparency and Health Literacy

- "The more we can do to raise the collective health literacy of our society is probably going to pay off pretty well in the long-run."

  – *Payer*

- "For your national numbers where about one in five trips to the emergency department you're going to be seen by out-of-network physician as part of that care, even when the hospital's in-network."

  – *Research Institution*

- "The key factor that I want to drive home, which I touched on a little bit, is that this really is at its fundamental levels a market failure."

  – *Research Institution*

- "I think this is one of those issues where you can't really rely on the patient to initiate and figure this out for themselves. Transparency alone is not really going to solve the issue. Try picking your anesthesiologist. Even the hospital [said] 'half my anesthesiologists are in-network and half are out-of-network.' The anesthesiologist you see is whoever's on call and doing the rounds."

  – *Research Institution*

- "I think it's hard to imagine patients going to shop. No one knows what happened to choose their anesthesiologist."

  – *Research Institution*

- "When states act on this issue, it seems to be restricted by a federal law called ERISA, which basically pre-empt states from regulating self-insured employer plans, and most large employers self-insure, and are therefore responsible for the medical risk. The state is basically not allowed to tell [self-insured plans] what to pay. However, I think it's worth noting that the state does have overview over provider regulation. So if you are trying to

actually solve this problem, states have restricted themselves to just dealing with a fully insured part of the market. But there's no actually legal reason not to address this."

– *Research Institution*

- "Almost all care when a patient seeks medical care, almost every single time they are seeking out in-network care because it comes with lower cost sharing, etc. It is very rare that patients purposely go out-of-network. . . . And they're not purposely going out-of-network in these situations we're talking about... I think if you [should] make it effectively illegal to be an out-of-network anesthesiologist. . . . Patients don't choose, you're not selecting the anesthesiologist, you are selecting the surgeon or the hospital."

– *Research Institution*

- "This is a market failure because we allow the anesthesiologist to contract independently. For other physicians you have to be part of a network to see patients. And it is lucrative to be out-of-network."

– *Research Institution*

- We don't let nurses bill separately. They are integral to the care but don't bill separately. Anesthesiology should not be able to bill separately either."

– *Research Institution*

- "The average person doesn't comprehend the concept that there is absolutely no rhyme or reason to what a provider can bill. There's no regulation, there's no barometer in any sense."

– *Payer*

- "And when you get a market, like in some pockets of Tennessee, where you could literally have one, two, maybe three provider organizations that dominate a certain specialty like Emergency Room Services . . . they are essentially setting their own reimbursement."

– *Payer*

- "This was an industry failure, that we are creatures of incentives. And as an industry, we failed, and we set all the wrong incentives for this phenomenon to occur. As payers, when a bill came in and was emergency service wrapped around it, we insulate the customer, insulate the patient. The person making the consumer decisions now is completely insulated to what's going on behind the scene until they get a bill. And luckily, they started getting bills, because I think that's probably the only reason we're sitting here. Because patients starting to get pulled into this."

– *Payer*

- "From my perspective, we've long insulated the customer from too much of this. Just make it go away, right? Make the bill go away, and for too long, we just scrambled to make the bill go away. And this is not providing the right incentives for us to truly fix the

underlying issue. I shouldn't be able to tell a consumer that a hospital is in-network, if every provider practicing in the hospital is not in-network."

– *Payer*

- As an industry, healthcare payers and providers are experienced negotiators, but the incentives must be in place for a negotiation to be fair and arrive at a rate the works for both parties."

– *Payer*

- "So for transparency, it sounds good. And you had to be careful with that term; I think because it's very nebulous. We want more transparency. Most everyone here has talked about price transparency, and cost transparency and empowering consumers to be better shoppers. If they know the quality and the price, then they can generate this other nebulous term - value. And that's what everyone wants to drive our healthcare system towards - delivering more value. I think you have to be careful how you define value, because it can mean different things to different people."

– *Research Institution*

- "Estonia, small, Eastern European country that 1.3 million people that . . . have a card. That's your ID, and it's got everything you get from government services on it, including your healthcare, if you go to a doctor, they don't have your record, on Cerner or Epic systems. You have it on your card. Once you give them your card, or your credentials, which you can access without a card, they can then access your data and every doctor you've been to. And it just works."

– *Research Institution*

- "The notion that I would know my neighbor's price and my ability to act on that in a network negotiation are two wildly different things. The vast majority of providers in the U.S. are not price makers, they're price takers. So they don't have the leverage. If I know what the person across the street is paying, I can't turn around and just tell you, 'Hey, I want that price.' That's not how that negotiations works. It can in some circumstances, but small markets where there's only a handful of providers within the larger metropolitan areas, that's not the case."

– *Research Institution*

- "They are not in the dark about what their competitors are getting paid. In fact, we just brought in a contracting specialist because we're doing some direct contracting on behalf of some of our larger municipal employers. And they already know what the prices across the street is. So the notion that this would be additional information that might otherwise shift the market, I think is economically an overblown concern."

– *Research Institution*

- You can't manage what you can't measure. . . . First, understand your data and what it is costing you. The next piece is benefit design and education . . . structure benefits that include shared saving incentive or shared risk and build education around that."

– *Research Institution*

- Transparency is about a program and not a single price. You need to be in a plan long enough to know how to shop. Price transparency is nothing without an anchor. $2,000 or $8,000 for a procedure, how do you know what to pay without knowing what you should pay."

– *Research Institution*

- As a purchaser across state programs, to provide flexibility to employers, I think about payers being able to deploy a range of tools that improve enrollee experience and provide cost and quality transparency so consumers can shop for healthcare program."

– *Payer*

- "We are doing things like digital navigation, we are also implementing a new advocacy resource. We don't have it yet. But we are getting there. Because I can tell you even on my enterprise healthcare teams who deal with this every day, we just had an individual who had complications related to a premium, and she has spent hours and hours and hours trying to get those goals taken care of. And that's somebody who's educated in our healthcare."

– *Commercial Corporation*

- "27 hospitals rank as top on one ranking and at the bottom of the another one, so that makes it a little bit harder for consumers to understand what exactly they're paying for."

– *Provider and Research Institution*

- "[Price transparency tools] can be used and harnessed in good ways. But it really relies on a way to make it usable and navigable. . . . if you just publish the charges, that's a long list. And that is not usable to anybody. . . . the evidence isn't that direct where more data means better decision-making. [Data] a necessary condition, but it's not a sufficient condition."

– *Provider and Research Institution*

- "When you buy yourself a big screen TV, you're thinking in 10 years, it's going to get better, and competition is going to drive down that price. So it's a better value product and lower costs for you. But it seems sometimes in healthcare, we can have a lot of data out there and it just becomes even more and more confusing. The ability to make the right decision becomes more complex. So how do we keep trying to figure that out? where we either make the data manageable that everyone can read it? Or we tailor some of that data to the folks that need it and they understand it based on their needs."

– *Tennessee State Government Agency*

- "When we're talking about the State of Tennessee and you all are talking about plan design and having a very educated consumers . . . I'm a very educated person, and I look at it and it makes no sense to me. I feel like I've done everything right. You've educated me. I've seen red. I've seen green. I've seen stats and I still have to sit down and pick up the phone to ask how to maneuver through that. But when we're talking about people who are in crisis, who show up at the emergency room, and that's their single point of healthcare, how are we educating these folks who show up and say, 'I need this fixed, I have a problem. I have a healthcare issue I need fixed.' How do we let those people know what they're walking out of the door with?"

– *Tennessee State Government Agency*

- "It's the idea that patients and … others will know prospectively and up front what the cost of care is. What the services are … so they can make informed decisions. . . In most other industries you can create a product by design, called user-centered design. . . . It's the idea that you create a product, or a service based on what the end user is going to do with that product or service. That's why your iPhone is so slim. It wasn't designed for those they weren't asking. There's a full process when you ask [consumers] and usually in healthcare that doesn't exist. Healthcare is designed for me [a physician], the end user, the surgeon. When is my clinic open? When are my appointments? Those are physician-centric, provider-centric, and that's historically how healthcare has been raised and designed. So, it was important to us that we flipped that, that we really make it central that this work is a patient-centered experience."

– *Provider and Research Institution*

- "One of the things we come to the realization of is we can have great programs, but the public is not educated in how to make the best lifestyle choices . . . and they are not going to have optimal health."

– *Community Partner*

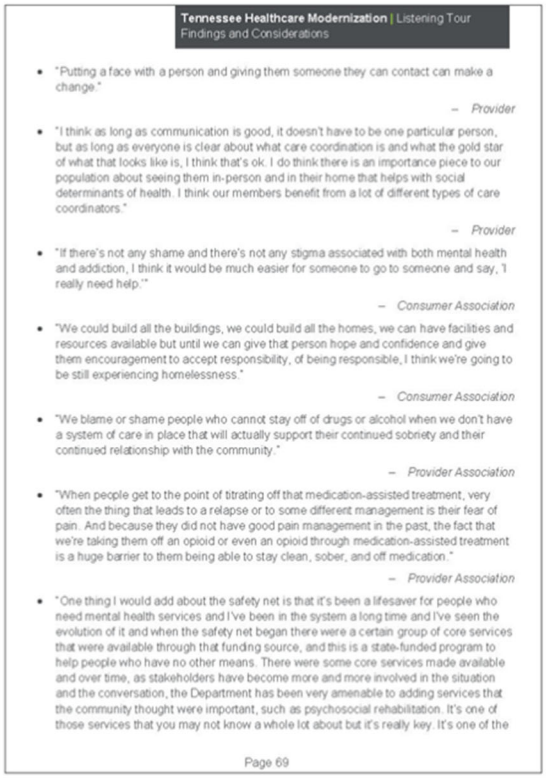
Representative Quotes – Other Compelling Quotes

- "The bottom line with engagement is you've got to build trust. It's all about building trust and relationships with these folks, and what we've found is that when we're able to effectively do that, they come back to us, and begin to utilize us as a trusted resource for helping them shape and guide their healthcare experience."

– *Payer*

- "75 percent of our members actually trust us to help make recommendations for which providers they should see and where they should seek care, and when we do make recommendations, 90 percent would recommend that provider that we [recommend] to them to a friend or colleague."

– *Payer*



Tennessee Healthcare Modernization | Listening Tour Findings and Considerations

- "Putting a face with a person and giving them someone they can contact can make a change."

  – *Provider*

- "I think as long as communication is good, it doesn't have to be one particular person, but as long as everyone is clear about what care coordination is and what the gold star of what that looks like is, I think that's ok. I do think there is an importance piece to our population about seeing them in-person and in their home that helps with social determinants of health. I think our members benefit from a lot of different types of care coordinators."

  – *Provider*

- "If there's not any shame and there's not any stigma associated with both mental health and addiction, I think it would be much easier for someone to go to someone and say, 'I really need help.'"

  – *Consumer Association*

- "We could build all the buildings, we could build all the homes, we can have facilities and resources available but until we can give that person hope and confidence and give them encouragement to accept responsibility, of being responsible, I think we're going to be still experiencing homelessness."

  – *Consumer Association*

- "We blame or shame people who cannot stay off of drugs or alcohol when we don't have a system of care in place that will actually support their continued sobriety and their continued relationship with the community."

  – *Provider Association*

- "When people get to the point of titrating off that medication-assisted treatment, very often the thing that leads to a relapse or to some different management is their fear of pain. And because they did not have good pain management in the past, the fact that we're taking them off an opioid or even an opioid through medication-assisted treatment is a huge barrier to them being able to stay clean, sober, and off medication."

  – *Provider Association*

- "One thing I would add about the safety net is that it's been a lifesaver for people who need mental health services and I've been in the system a long time and I've seen the evolution of it and when the safety net began there were a certain group of core services that were available through that funding source, and this is a state-funded program to help people who have no other means. There were some core services made available and over time, as stakeholders have become more and more involved in the situation and the conversation, the Department has been very amenable to adding services that the community thought were important, such as psychosocial rehabilitation. It's one of those services that you may not know a whole lot about but it's really key. It's one of the

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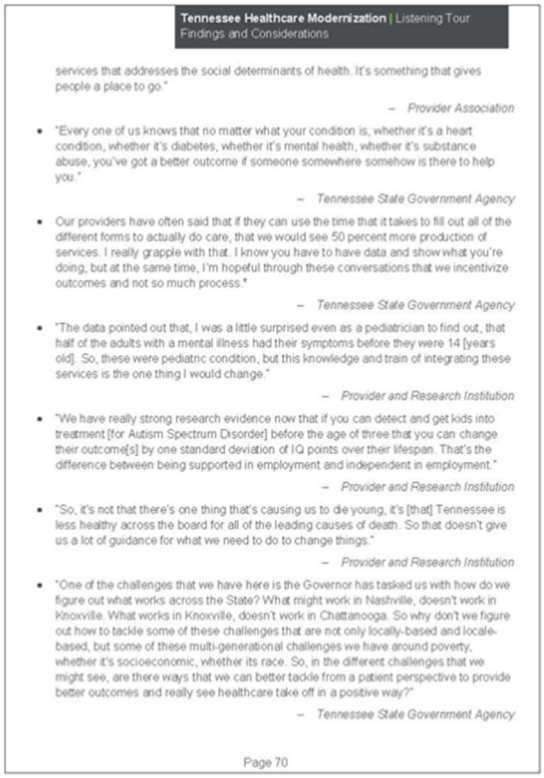

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services that addresses the social determinants of health. It's something that gives people a place to go."

– *Provider Association*

- "Every one of us knows that no matter what your condition is, whether it's a heart condition, whether it's diabetes, whether it's mental health, whether it's substance abuse, you've got a better outcome if someone somewhere somehow is there to help you."

  – *Tennessee State Government Agency*

- Our providers have often said that if they can use the time that it takes to fill out all of the different forms to actually do care, that we would see 50 percent more production of services. I really grapple with that. I know you have to have data and show what you're doing, but at the same time, I'm hopeful through these conversations that we incentivize outcomes and not so much process."

  – *Tennessee State Government Agency*

- "The data pointed out that, I was a little surprised even as a pediatrician to find out, that half of the adults with a mental illness had their symptoms before they were 14 [years old]. So, these were pediatric condition, but this knowledge and train of integrating these services is the one thing I would change."

  – *Provider and Research Institution*

- "We have really strong research evidence now that if you can detect and get kids into treatment [for Autism Spectrum Disorder] before the age of three that you can change their outcome[s] by one standard deviation of IQ points over their lifespan. That's the difference between being supported in employment and independent in employment."

  – *Provider and Research Institution*

- "So, it's not that there's one thing that's causing us to die young, it's [that] Tennessee is less healthy across the board for all of the leading causes of death. So that doesn't give us a lot of guidance for what we need to do to change things."

  – *Provider and Research Institution*

- "One of the challenges that we have here is the Governor has tasked us with how do we figure out what works across the State? What might work in Nashville, doesn't work in Knoxville. What works in Knoxville, doesn't work in Chattanooga. So why don't we figure out how to tackle some of these challenges that are not only locally-based and locale-based, but some of these multi-generational challenges we have around poverty, whether it's socioeconomic, whether its race. So, in the different challenges that we might see, are there ways that we can better tackle from a patient perspective to provide better outcomes and really see healthcare take off in a positive way?"

  – *Tennessee State Government Agency*

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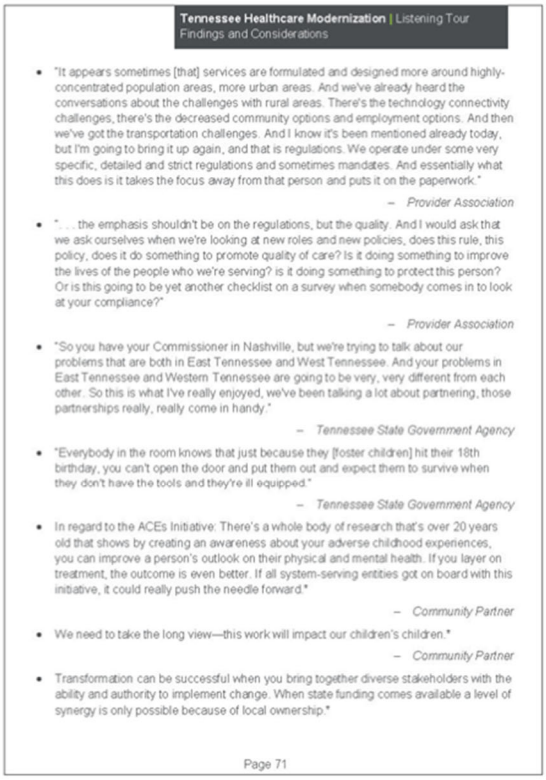

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- "It appears sometimes [that] services are formulated and designed more around highly-concentrated population areas, more urban areas. And we've already heard the conversations about the challenges with rural areas. There's the technology connectivity challenges, there's the decreased community options and employment options. And then we've got the transportation challenges. And I know it's been mentioned already today, but I'm going to bring it up again, and that is regulations. We operate under some very specific, detailed and strict regulations and sometimes mandates. And essentially what this does is it takes the focus away from that person and puts it on the paperwork."

  – *Provider Association*

- ". . . the emphasis shouldn't be on the regulations, but the quality. And I would ask that we ask ourselves when we're looking at new roles and new policies, does this rule, this policy, does it do something to promote quality of care? Is it doing something to improve the lives of the people who we're serving? is it doing something to protect this person? Or is this going to be yet another checklist on a survey when somebody comes in to look at your compliance?"

  – *Provider Association*

- "So you have your Commissioner in Nashville, but we're trying to talk about our problems that are both in East Tennessee and West Tennessee. And your problems in East Tennessee and Western Tennessee are going to be very, very different from each other. So this is what I've really enjoyed, we've been talking a lot about partnering, those partnerships really, really come in handy."

  – *Tennessee State Government Agency*

- "Everybody in the room knows that just because they [foster children] hit their 18th birthday, you can't open the door and put them out and expect them to survive when they don't have the tools and they're ill equipped."

  – *Tennessee State Government Agency*

- In regard to the ACEs Initiative: There's a whole body of research that's over 20 years old that shows by creating an awareness about your adverse childhood experiences, you can improve a person's outlook on their physical and mental health. If you layer on treatment, the outcome is even better. If all system-serving entities got on board with this initiative, it could really push the needle forward."

  – *Community Partner*

- We need to take the long view—this work will impact our children's children."

  – *Community Partner*

- Transformation can be successful when you bring together diverse stakeholders with the ability and authority to implement change. When state funding comes available a level of synergy is only possible because of local ownership."

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Appendix D Reservation of Rights

Submission of this proposal is not an indication of Guidehouse Inc.'s ("Guidehouse") willingness to be bound by all of the terms presented in the State of Nebraska Department of Health and Human Services ("DHHS") Reduced Reliance on Congregate Care RFP 114897 O3 ("RFP,"). This proposal in response to the Reduced Reliance on Congregate Care RFP 114897 O3 does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Final acceptance of this engagement by Guidehouse is contingent upon successful completion of Guidehouse's acceptance procedures. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory vendor contract including modifications to certain RFP terms and conditions (including, without limitation, the RFP's specific contract section or attachments).

Given our history of successfully negotiating mutually agreeable terms with similar state agencies we do not anticipate any difficulty in reaching a contractual agreement that will enable us to provide the professional services which you are requesting, while protecting the interests of both parties.

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