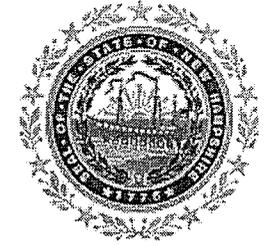


# NH Department of Health and Human Services

Health and Human Services Oversight Committee

Nick Toumpas, Commissioner

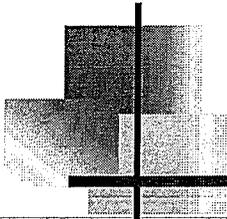
July 8, 2011



# Today's Agenda

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- Department Update
  - Yesterday, today and tomorrow
- Care Management Discussion
  - Checkpoint on progress and discussion
- Medicaid Annual Report
  - Review of SFY 10 Annual report
- State Health Profile
  - Overview of key issues from report



# Department Update



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SFY 11 Summary and results  
Projected Surplus\_Shortfalls for SFY 12/13  
Opportunity for transformation  
Short and long term challenges



# SFY 11 Caseloads

	SFY08	SFY09	SFY10	SFY11
Unduplicated Persons	119,806	131,148	145,949	152,821
		9.5%	11.3%	4.7%
Medicaid Persons	102,913	107,488	117,025	119,612
		4.4%	8.9%	2.2%
FANF Persons	10,728	12,026	14,098	13,696
		12.1%	17.2%	-2.8%
APTD Persons	6,518	7,279	8,284	8,794
		11.7%	13.8%	6.2%
Food Stamp Persons	62,178	72,973	99,219	112,302
		17.4%	36.0%	13.2%

- Annual averages over past 4 years (see dashboard for exact counts)
- Caseload growth is the major driver of costs
- No eligibility changes

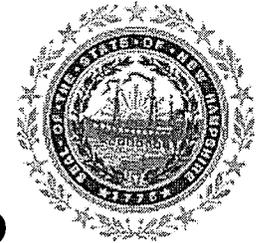


# SFY10 & 11 Fiscal Results

## Cost Reduction Initiatives

Rounded to \$000	SFY10		SFY11	
	General Funds	Total Funds	General Funds	Total Funds
Step 1 Governor's Layoff	\$2,871	\$8,577	\$5,720	\$10,196
Step 2 Cost Reduction	\$27,609	\$39,475	\$41,929	\$71,023
Step 3 Cost Reduction	\$6,424	\$4,045	\$6,887	\$6,845
<b>Total Reductions</b>	<b>\$36,904</b>	<b>\$52,097</b>	<b>\$54,536</b>	<b>\$88,064</b>

- Department projected \$40M/yr shortfalls at beginning of biennium
- Initiated cost reductions over the biennium
- Cumulative reductions in rates and maintaining high vacancy rates contributed to savings
- Personnel vacancies went from 272 positions (8.1%) to 581 positions (17.4%) over 2 years
- Through the reductions, we were able to achieve savings and met lapse obligation

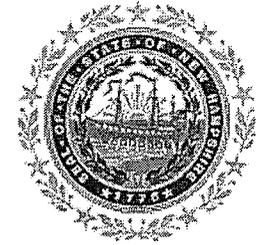


# Fiscal Challenges SFY12-13

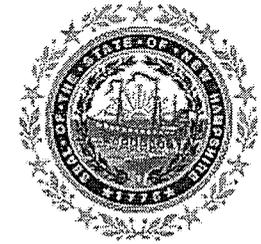
	SFY12	SFY13
<b>Appropriation Shortfalls</b>	(\$9,915)	(\$10,242)
<b>Savings Budgeted From Transformations</b>	(\$14,644)	(\$35,270)
<b>Program Shortfall including termination pays for laid off employees and retirees</b>	???	???
<b>Contingencies-Federal audits</b>	???	???

- Department is developing or has plans to meet known shortfalls or reduction targets
- Legislation is required to address SSI in TANF and FANF, impacts of ~\$7.8M per year
- Potential significant shortfalls from the contingencies segment

# Legislative Intent for System Transformation



- Managed Medicaid Program
  - Payment and delivery reform with Prepaid Mental Health
  - SCHIP Integration
- Delivery System Consolidation and Integration
  - Contract consolidation in all areas
- District Office Modernization
  - Consolidation of field offices
  - Use of imaging, speech to text, web services
- Environmental Services; Water Quality Laboratory
- Tele-video for child services & overnight assessments for mental health services
- Privatize certain Department operations
  - Transitional Housing Services
  - Tirrell House

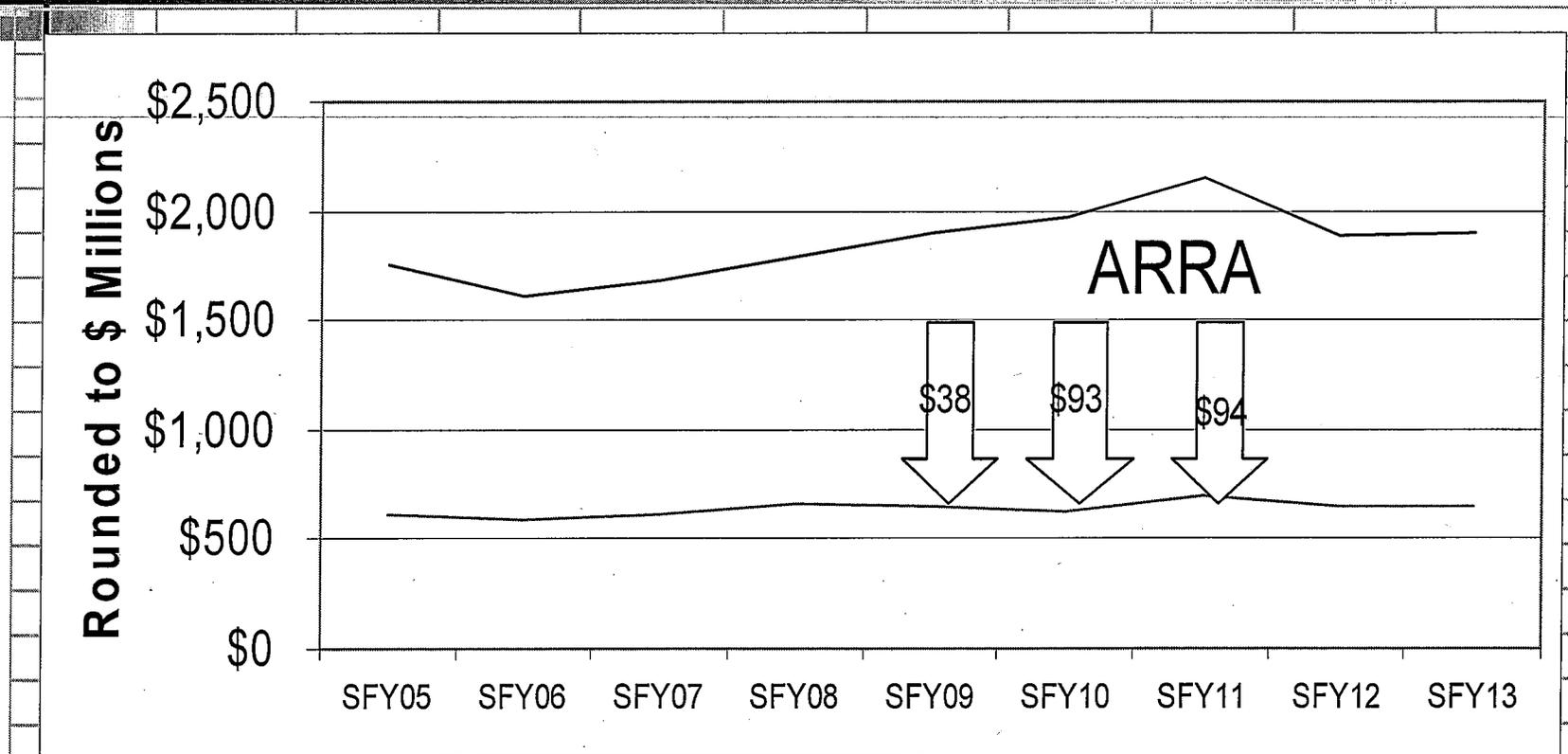


# Number of Challenges

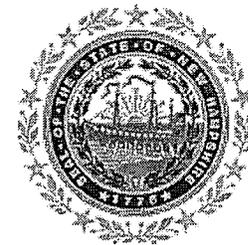
- Implementation of proposed budget reductions will mean loss of services
  - Includes: CHINS, Congregate Housing, New Hampshire Hospital, Childcare, Substance Abuse, Cash Assistance
  - Not one segment of client segments unaffected
- Uncompensated Care and Disproportionate Share Hospital (DSH)
  - Potential for \$35M disallowance from 2004 DSH audit
  - DSH 2011
  - Reductions to DSH program for non-critical access hospitals
- IT Funding
  - Reductions to core infrastructure
  - MMIS enhancement funding gap
- The response to the Affordable Care Act
  - Presents opportunities and challenges
- DHHS staffing resources
  - 372 positions eliminated
  - 124 projected layoffs...although many will be reassigned
  - Uncertain impact of State consolidation of HR and business operations
  - Unknown impact should there be no agreement on the healthcare savings
- Litigation: present and on the horizon
  - Focused on driving policy change
- Federal government actions on funding
  - Expect to see reductions in number of key programs



# Historical View Total Funds & General Funds



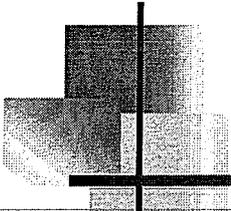
	SFY05	SFY06	SFY07	SFY08	SFY09	SFY10	SFY11	SFY12	SFY13
Total Funds	\$1,749	\$1,610	\$1,679	\$1,792	\$1,899	\$1,972	\$2,146	\$1,888	\$1,903
General Funds	\$617	\$592	\$612	\$661	\$644	\$629	\$692	\$651	\$647



Thank You



[NToumpas@DHHS.State.NH.US](mailto:NToumpas@DHHS.State.NH.US)  
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# Care Management

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Setting the context

Program goals and objectives

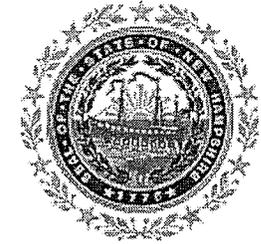
Alternative concept models for program

Key considerations

Program plan

Reference materials

Next Steps



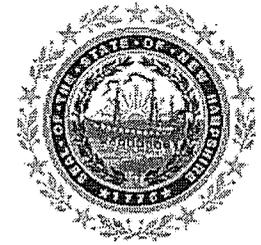
# Medicaid Profile

Category	Enrolled	Percent	Expenditures	Percent
Low Income Children	96,035	58.0%	\$ 224,341,503.00	22.1%
Low Income Adults	26,139	15.8%	\$ 81,500,086.00	8.0%
Severely Disabled Children	1,816	1.1%	\$ 37,997,947.00	3.7%
Disabled_Physical	10,649	6.4%	\$ 201,241,500.00	19.8%
Disabled_Mental	13,382	8.1%	\$ 219,639,929.00	21.6%
Elderly	11,682	7.1%	\$ 246,343,546.00	24.2%
QMB/SLMB	11,335	6.8%	\$ 5,512,028.00	0.5%
<b>Total</b>	165,609	100.0%	\$1,016,708,930.00	100.0%

- Summary of SFY 10 Medicaid enrollees and service costs\*
- 49% of costs for Long-term care, 40% for medical and behavioral health services
- Elderly and disabled are 22% of enrollees but 65% of costs
- Dual eligibles (Medicare and Medicaid) account for 17% of enrollees, 44% of costs

<http://www.dhhs.nh.gov/ombp/documents/medicaid10.pdf>

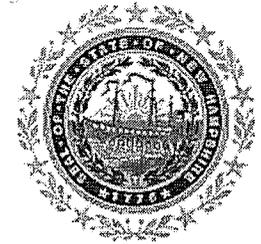
\*Numbers not additive due to number of unique people without regard to enrollment group



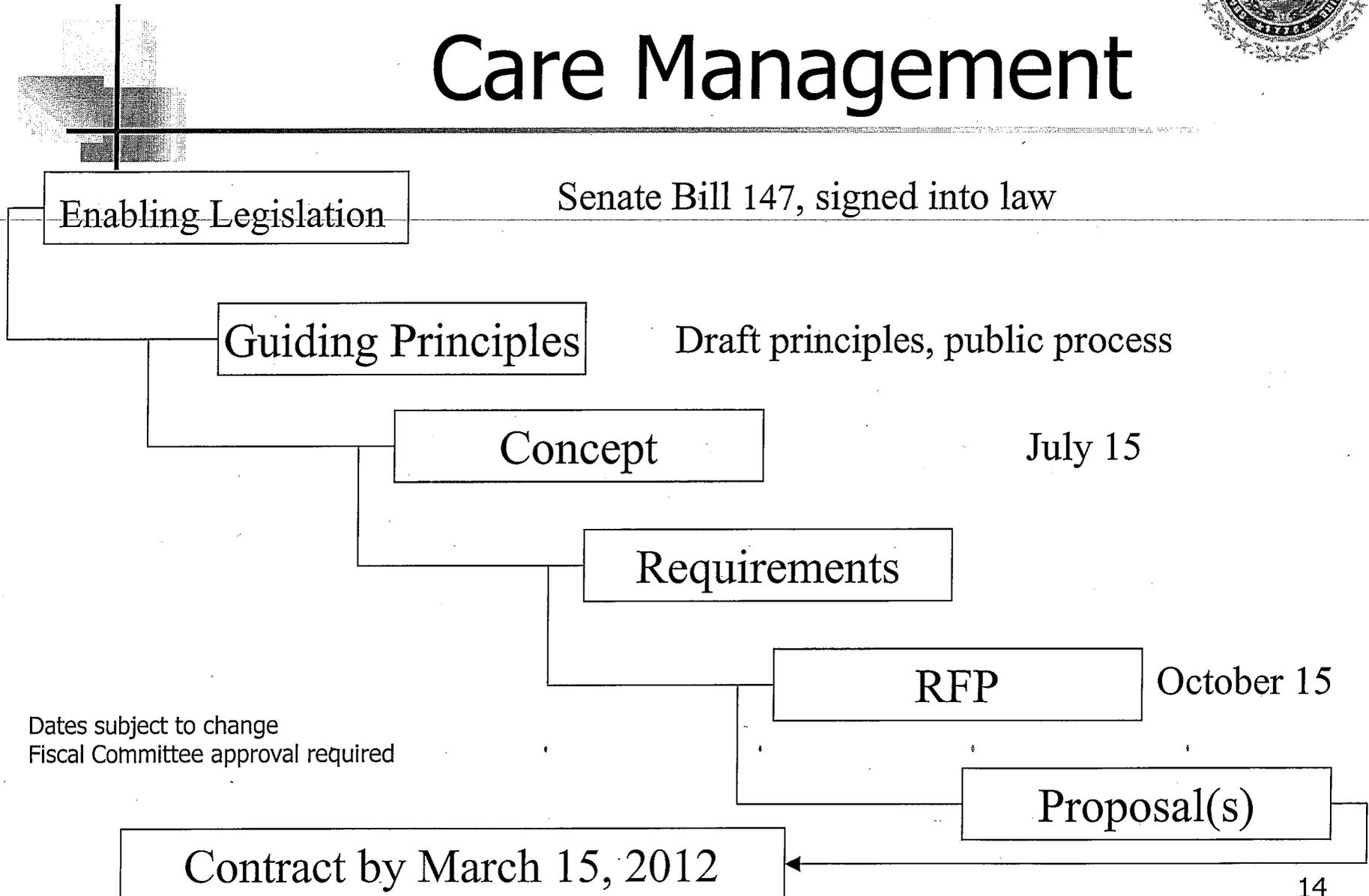
# Program Goals

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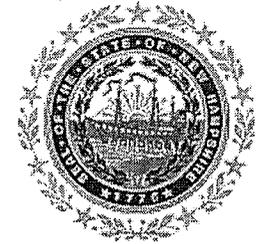
- Improve beneficiary health
- Reimburse based upon outcomes
- Support continuity of care
- Ensure access to primary care and prevention
- Promote shared decision making
- Improve budget predictability
- Compliance with federal and state law
- Prepare for 2014 Medicaid expansion
- Achieve savings of \$16M in GF



# Care Management

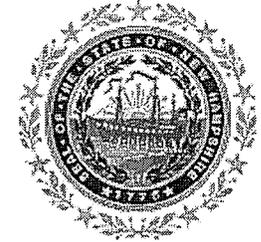


Dates subject to change  
Fiscal Committee approval required



# Actions to Date

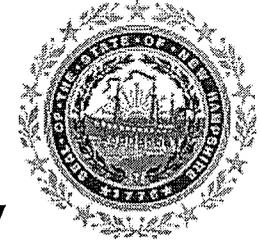
- DHHS continues with Medicaid related cost savings initiatives
  - The use of managed care tools on the TANF population has been successful
  - Initiatives in other segments have continued and will be integrated into overall strategy
- Draft 5-phase project plan
  - Planning; Proposal; Contract; Design, development and implementation; Operations
- Convened a cross functional "design team" to evaluate possible models
  - Model design evaluation and options
  - Initiated scan of Medicaid Managed Care in other States
- Working with CMS re optional models and to identify technical resources
- Finalized contract with UNH for securing technical assistance
  - Actuarial analysis, financial, legal, contract design, engagement, RFP draft, project management, other
- Developed "guiding principles" draft (10 principles, see Slides 29-31)
  - Reviewed with Medical Care Advisory Committee
  - Securing resource via UNH contract for public process and outreach
    - Consumers, providers & advocates, caregivers, other "non-stakeholder" stakeholders
- Refining initial actuarial analysis for population segments
  - Integration of behavioral health analysis
- Assessing information systems readiness
  - New MMIS in testing built for fee-for-service model
- Outlining our strategy for execution
- Developing contingency plans to insure targeted savings are achieved



# Anticipated Savings Sources

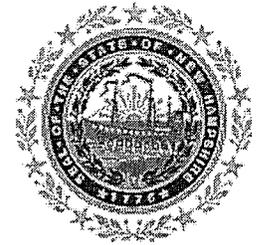
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- Increase timely access to primary care
- Implement single point of accountability for care coordination
- Better manage transitions between sites of care (e.g. hospital to home)
- Reduce avoidable hospital admits and readmits
- Reduce emergency department use for primary care
- Improve compliance with recommended care
- Reduce duplication of tests
- Greater integration of public health



# Implementation Strategy

- Seek technical assistance in planning and design phase
- Request For Proposal that allows bidder flexibility to propose a care management model to achieve objectives
  - Traditional, capitated plan
  - Accountable Care Organization
  - Administrative Services Organization
  - Combination of any above
- Best value, quality, efficiency, potential for savings and innovation
- We will define the REQUIREMENTS and allow the "market" to respond

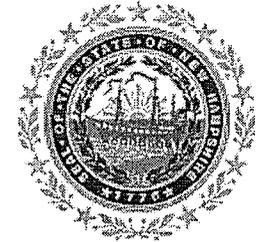


# Models of Managed Care

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Insert updated models  
Industry models  
Work-in-progress

# LEGEND



## Guiding Principles Invoked in ALL Contracts:



Person/Family centered; informed choices



Within available resources



Quality performance outcomes: fair, equitable, reasonable.

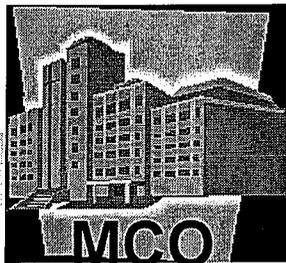


Medical Home



Demonstrated care coordination for shared consumers

# MODELS



**MANAGED CARE ORGANIZATION (MCO):** An entity authorized by law to provide covered health services on a capitated risk basis. This organization combines the functions of health insurance, delivery of care, and administration.



**ACCOUNTABLE CARE ORGANIZATION (ACO)** An entity or group (Consortium of Providers) which accepts responsibility for the cost & quality of care delivered.

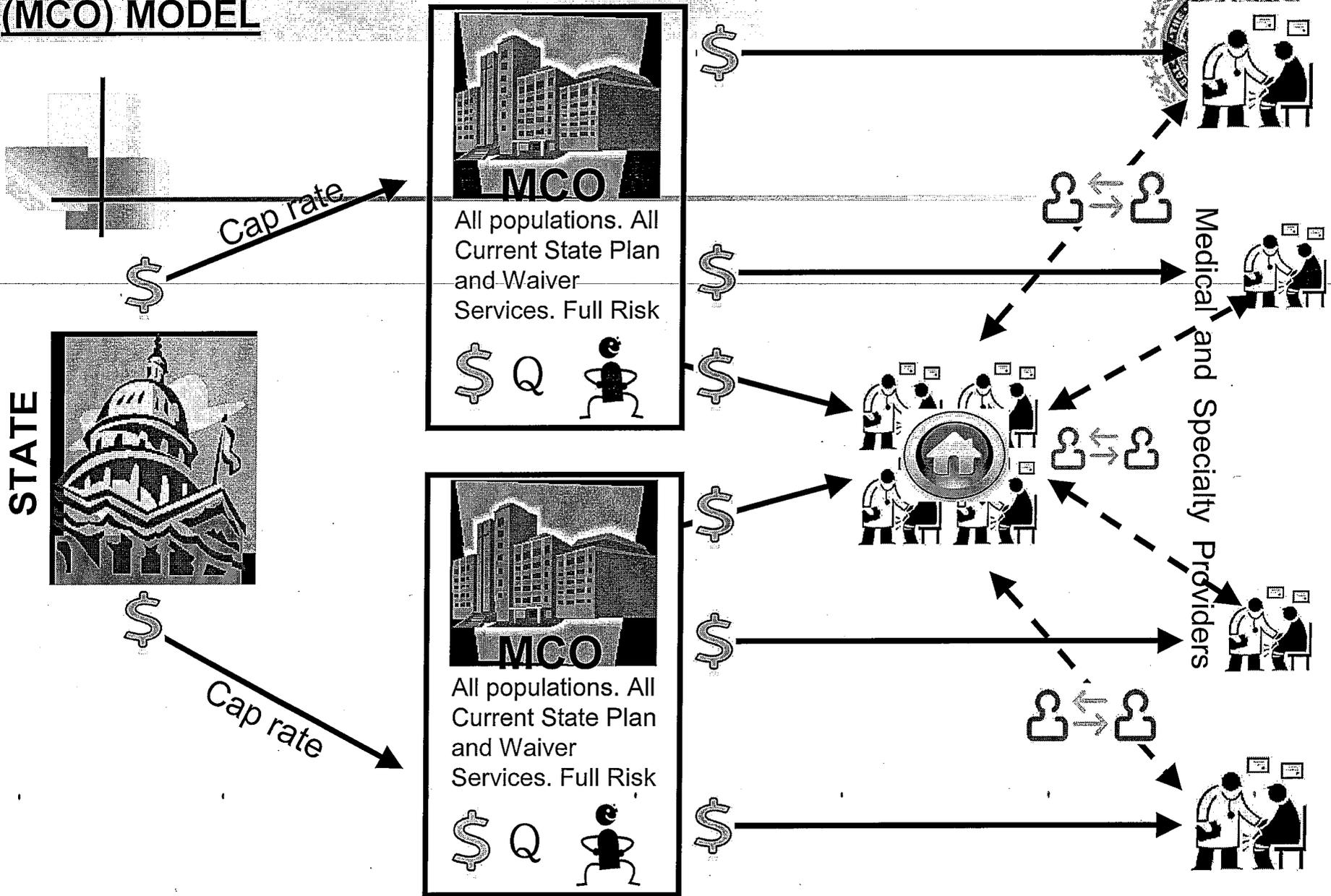


**ADMINISTRATIVE SERVICE ORGANIZATION (ASO)** :An entity providing administrative services on behalf of the State.



**PRIMARY CARE CASE MANAGEMENT (PCCM):** An entity contracting with State to furnish case management (CM) services. Medicaid members choose a primary care physician (PCP) who provides basic medical care & authorizes referrals to specialty care. The PCP receives small monthly fee to coordinate care.

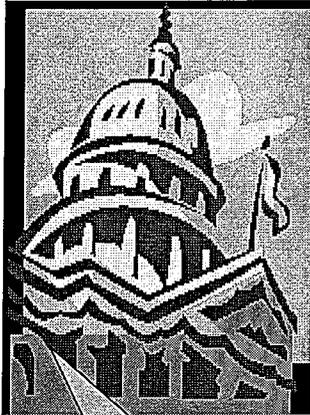
# MANAGED CARE ORGANIZATION (MCO) MODEL



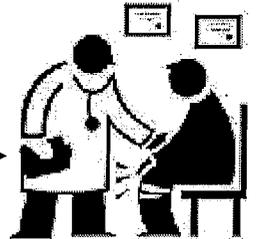
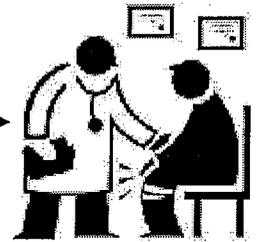
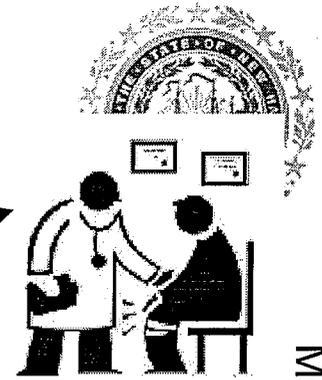
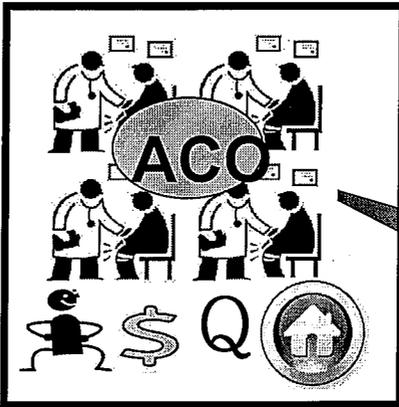
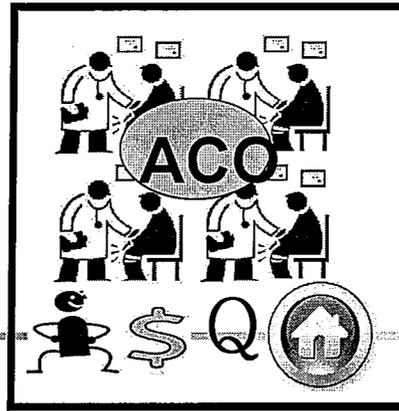
\* Note: Regardless of model State will still be responsible for "Claims run-off", for FFS provided prior to implementation but due to normal lag will be paid over next 6-12 months.

# ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL

STATE



CAP RATE



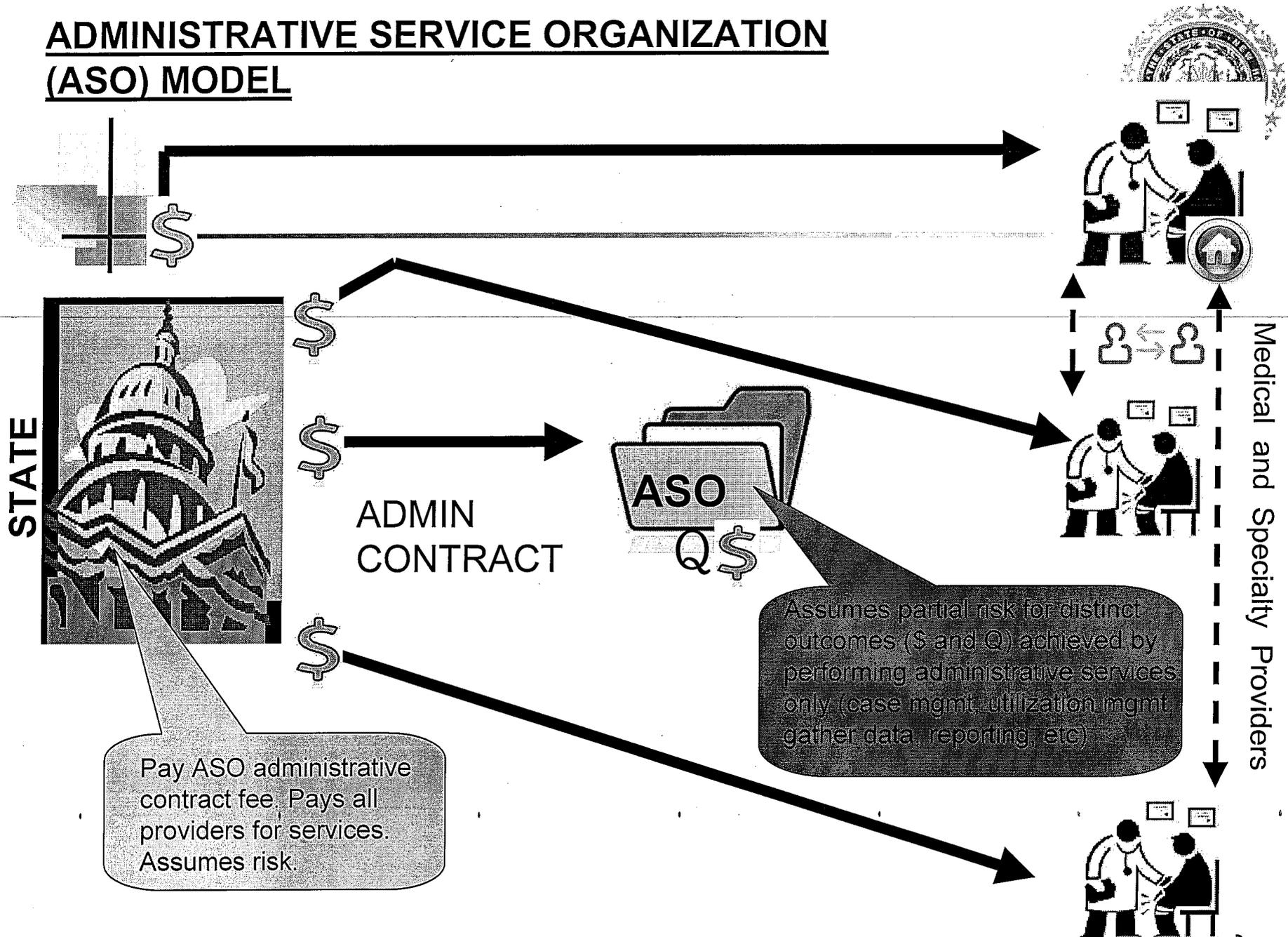
Medical and Specialty Providers

Pays ACO fixed cap rate, budget predictability, defined contract outcomes/goals/incentives

Pays claims contracts w/ providers utilization mgmt. assumes risk

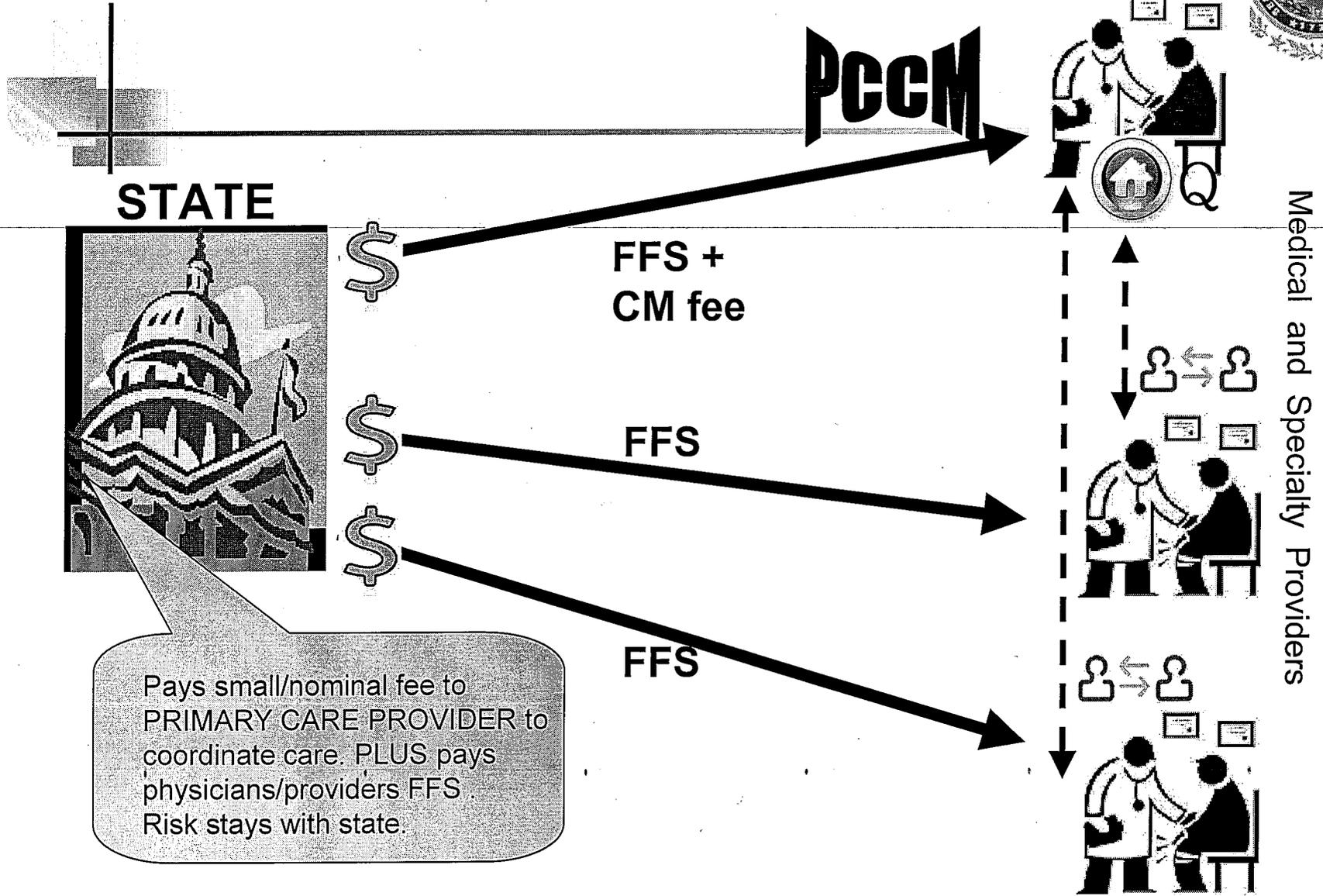
\* Note: Regardless of model State will still be responsible for "Claims run-off"

# ADMINISTRATIVE SERVICE ORGANIZATION (ASO) MODEL



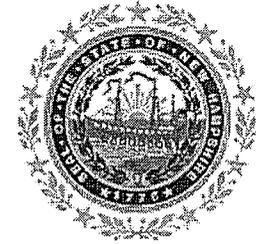
\* Note: Regardless of model State will still be responsible for "Claims run-off"

# PRIMARY CARE CASE MANAGEMENT (PCCM) MODEL



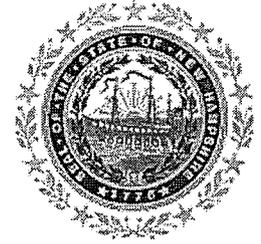
Pays small/nominal fee to **PRIMARY CARE PROVIDER** to coordinate care. **PLUS** pays physicians/providers **FFS**. Risk stays with state.

\* Note: Regardless of model State will still be responsible for "Claims run-off"



# Key Considerations

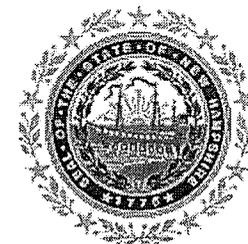
- Federal regulations
  - Require least 2 vendors
- Must have a clear plan for the ACA Medicaid expansion 1/1/14
  - Estimated 50,000 new enrollees
- A robust stakeholder engagement process is vital to success
- Timelines for approvals and oversight are tight
  - CMS contingent on selected model(s)
  - Legislative committees
    - Fiscal, HHSO, Joint Healthcare Reform Oversight
  - G&C Approvals
- Integration of HB 2 requirement for prepaid behavioral health plan
- Regional variances
- NH's rates for services are low
  - CMS is aggressively monitoring to insure access is not impacted
- Claims lag and run out is a significant issue and will require vendor collaboration
- Systems infrastructure readiness
  - MMIS targeting July 2012
  - Eligibility Systems
- Level and pace of change to delivery systems is significant
  - Mandates of SB 151 need to be factored in
- Contingencies to achieve savings targets must be crafted
- Threat of litigation is a factor that must be monitored
- Impact of further reductions at the Federal level



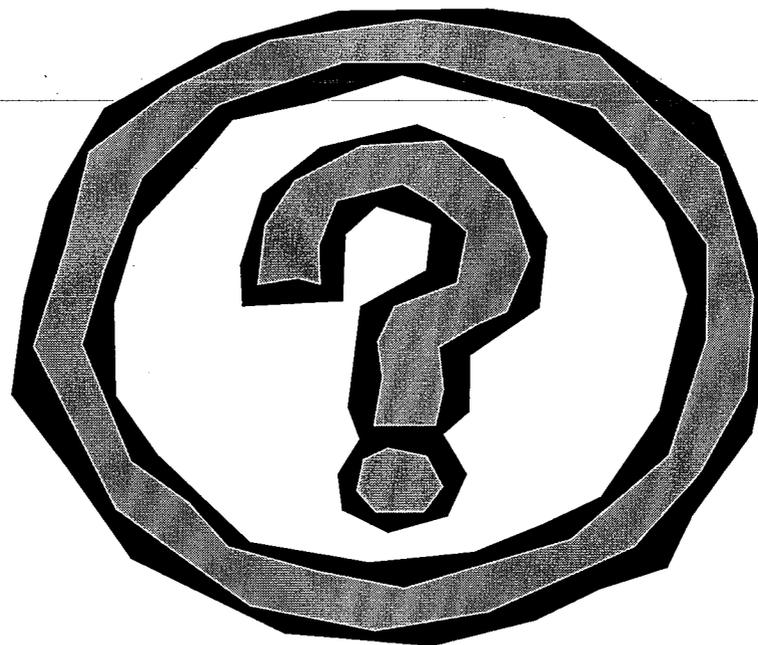
# Next Steps

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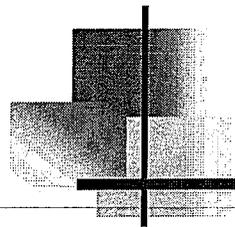
- MCO model for TANF population
- Continued work on concept for disabled and elderly populations and services
- Initiate public process
- Brief Fiscal monthly on progress
- Initiate RFP development
- Strategies to address key considerations must be finalized



Thank You

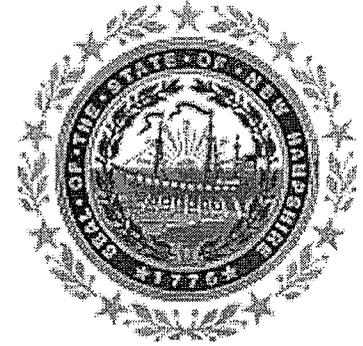


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(O) 603-271-4331, (C) 603-545-4995

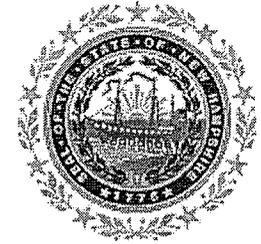


# Managed Care

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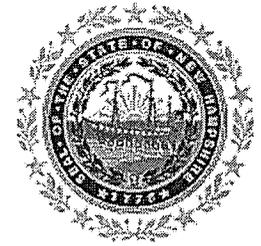
## Reference Materials



# Draft Guiding Principles

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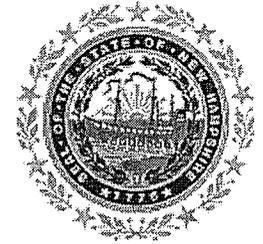
1. All services will be person/family centered based on an informed choice, consumer driven model
2. Services will be designed to achieve intended outcomes within the context of available financial and human resources
3. Clients and their caregivers will be educated and informed about their options
4. The value of services will be measured by health outcomes achieved per dollar spent (cost)



# Draft Guiding Principles

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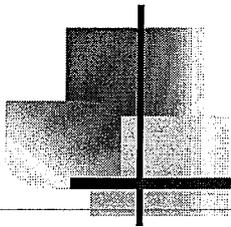
5. All participants within the system, including program administrators, providers, families and clients, will be held accountable to achieve a high level of care through transparent process of continuous evaluation of quality and cost
6. All participants within the system will be compliant with state and federal laws, regulations and contracts
7. Culturally competent care will be integrated and coordinated across all systems to achieve the intended physical, behavioral and human service outcomes of all populations



# Draft Guiding Principles

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8. Services will be provided in a fair, equitable and reasonable manner using evidence-based approaches
9. Stakeholders will be engaged in the design, development and implementation of the system of care
10. The care management system will be responsible for measuring the impact of services on the Medicaid population as a whole and will continue to improve services to achieve better population health.

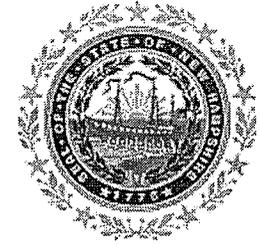


# Medicaid Managed Care: Assessing the Potential in NH

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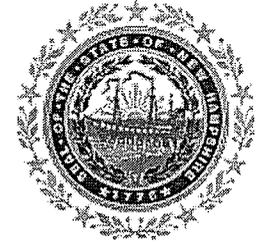


Senate Finance Committee  
February 17, 2011  
Katie Dunn, MPH  
Medicaid Director



# What is Managed Care?

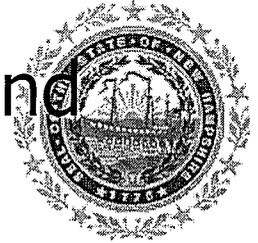
- Managed care is an approach to delivering and financing health care by providing coordinated services to a group of enrollees through a network of providers and by managing the utilization of health care services.
- Multiple managed care strategies for organizing and financing care.
  - Traditional managed care: Full and Partial Risk Bearing
  - Administrative Services Organization (ASO)
  - Accountable Care Organization (ACO)



# Types of Managed Care

- **Primary Care Case Management (PCCM):** Primary care practitioner receives a monthly case management fee per patient to coordinate care and make referrals to specialty care. Services reimbursed fee-for-service.
- **Patient Centered Medical Home (PCMH):** Similar to PCCM, but with greater expectations of the practice. "A model of care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care...with coordinated care." (NCQA)
- **Managed Care Organization (MCO):** A MCO which assumes responsibility for a global budget, outcomes, insurance risk, and claims processing.
  - **Partial Risk Contracting:** MCO agrees to provide some, but not all services for a set amount per person per month (PMPM). Some services continue to be reimbursed on a fee-for-service basis. Or provider limits risk to a corridor around a targeted amount. An example of a corridor is a cost sharing/gain around +/- 10% of a target amount.
  - **Full risk contracting:** MCO agrees to provide all services for a set amount PMPM basis (full capitation). The contractor is at risk for costs that exceed the capitation. Contracts often include risk adjustment based on the health status and resource use of their enrollees to protect plans from excessive risk.
- **Administrative Service Organization (ASO):** A contractor that assumes responsibility for specific administrative services focused on utilization management and/or care management. Contractor at risk for process outcomes and/or health outcomes appropriate to the scope of work.
- **Accountable Care Organization (ACO):** A provider organization that assumes accountability for a global budget and health outcomes for a specific population and services.

# Why States Adopt Risk-based Contracts and other Global Budget Approaches



- Improve accountability and measurement of quality of care, health status, and outcomes
- Reduce per member cost
- Make expenditures more predictable
- Align incentives of payers, providers, and members

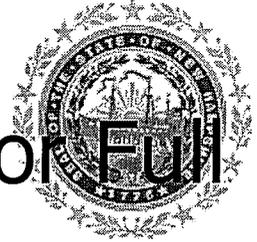


# Managed Care Federal Authority

Eligibility Group	Voluntary Enrollment	Mandatory Enrollment
Parents and children	State Plan Amendment	State Plan Amendment
Elderly and Disabled Adults	State Plan Amendment	State Plan Amendment
Dually eligible, special needs children	State Plan Amendment	Section 1915(b) or 1115(b) waiver

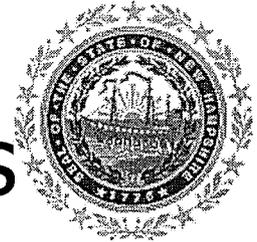
*DHHS finds that it will be possible to receive federal permission to implement risk-based managed care contracts. The range of federal authority options goes from easier to obtain with trade off of fewer design options to harder to obtain with more design options.*

# CMS Managed Care Requirements for Risk Contract



- State must provide beneficiary a choice of not less than 2 entities.
- Individuals must be permitted to terminate or change enrollment for cause at any time; without cause 90 days from enrollment or at least every 12 months thereafter.
- State must present individuals with comparative information chart on each MCO.
- Beneficiary protections include access to emergency services, provider-enrollee communications, grievance procedures, demonstration of adequate capacity and services.
- State must have a Quality Improvement assessment and improvement strategy that includes contracting with an EQRO.
- MCO may not directly distribute marketing materials to beneficiaries.
- PMPM rates must be certified by independent actuary and approved by CMS as "actuarially sound."

# Other State Medicaid Programs



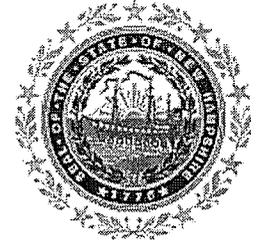
- Variety of care management programs pursued

- PCCM and capitated MCO forms
- Programs often not statewide, do not include all eligibility groups, and are not comprehensive in services included.
- Even with managed care, states continue to wrap around coverage and carve out services for separate management.
- Connecticut dropping full risk managed care contract. "Too expensive".

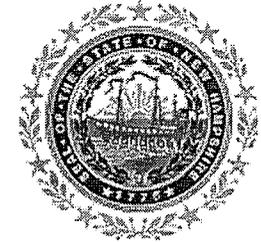
# Literature Review: Summary

## Risk-based Medicaid Managed Care Outcomes

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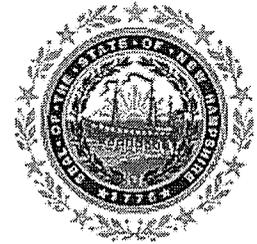
- The preponderance of peer-reviewed literature reports that managed care is associated with...
  - Greater likelihood of a usual source of care for members
  - Less emergency department use
  - Reduction in preventable hospital admissions
  - Greater smoking cessation and prenatal care among pregnant women and
  - Greater use of community services, and less use of institutional services among people with long-term supports needs.



# Lessons Learned From Other States

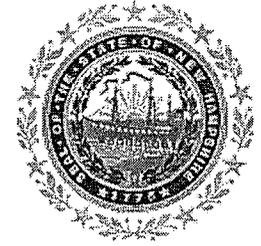
- Must adapt to local conditions – full risk contract may not be possible throughout state.
- Engage stakeholders early and continuously.
- Need 3-5 year commitment to see program mature.
- Measure performance which requires early attention to data gathering and attention to analysis.
- Build effective administrative infrastructure: contract development & monitoring, federal reporting, quality monitoring.
- First year MCO rates reasonable. Subsequent years rates increase substantially to account for investment in provider network reimbursement and infrastructure. Administrative overhead costs to MCO 11% – 15%.

# NH's Voluntary Managed Care Program

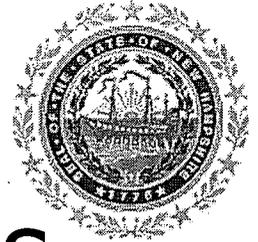


- NH Medicaid had a *voluntary* managed care (VMC) program for TANF population only from 1999 to 2003.
- Began with 3 insurers. By 2003 only 1 response to RFP due to inability to maintain provider network due to rates needed to retain providers.
- Actuaries looked at actual SFY 01 and 02 benefit utilization data compared to premiums paid.
- VMC costs at that time were higher than adjusted FFS costs and it would cost the state much less than the 12-15% to administer the same services under FFS.
- Elimination of VMC resulted in \$8M in savings that was used to close budget deficit and respond to dental lawsuit.

# Current Day NH Medicaid Managed Care Strategies



- Efforts to date have focused on medical services. Have not included behavioral health and LTC/Home & Community Based services.
- Progress to implement managed care has been informed by decisions of NH Legislature
  - Pharmacy Benefit Manager (Magellan)
  - Disease Management (1915 waiver) (McKesson)
  - Enhanced Care Coordination Pilot (Schaller)
  - Preferred provider contracting e.g. diabetes supplies
  - Application of Evidence Based Guidelines
  - Utilization Management (prior authorization, service limits, inpatient review, discharge planning)
  - Physician profiling and detailing
  - Quality Assessment and Improvement
- Bureau of Behavioral Health Initiative
  - Developing pre-paid plan with capitated payments for CMHCs
  - Leverage and integrate work completed to date.



# National Findings on Savings

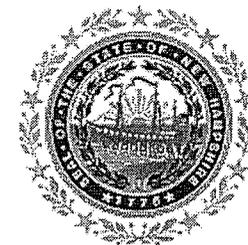
- Savings range from 0.5% to 20%
- Dependencies:
  - Efforts state has taken to manage care through initiative such as PBMs and utilization management strategies
  - Savings greater in urban vs. rural areas
  - Savings greatest for older persons and persons with disabilities than for parents and children
  - Savings greater in risk-based than in PCCM
  - Savings derive primarily from reducing hospital use
- OMBP's Milliman Study: 0% - 5% maximum with higher end based upon including all populations due to managed care strategies DHHS has already put in place.



# Factors Affecting Savings

- Scope of care management
  - Who and what services/diseases/conditions managed?
- Intensity and coordination of care management
  - Role of PCP, single case manager, telephonic vs. in person?
- Active provider network development
  - Training and implementation of PCPs as care managers.
- Geographic coverage of services areas
- How program rolled out
  - Phase in or statewide?
  - Start date of program
- How will the program affect PCP behavior?
  - Changed practices or just better willingness to accept Medicaid beneficiaries as regular patients?
- Amount of attention paid to contract definition and rates paid for care management activities.

# Results of Managed Care Request for Information



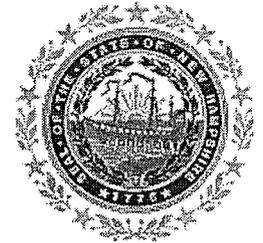
- 12 responses were received (with 10 answering all or most of the questions).
- Nine respondents were Health Maintenance Organizations or Managed Care Organizations; two were Administrative Service Organizations (although both performed some functions of a HMO/MCO), one response was a letter of concern, providing no feedback for program design.
- Of nine HMOs/MCOs, six were for-profit national firms; three were New England regional not-for profit entities.
- For risk-based arrangements, one respondent indicated using full capitation for all services, the rest used a broader array of payment methods (risk/incentive arrangements for either a limited number, half, most, or all of their services).
- None of the respondents discussed the impact Medicaid Managed Care might have on rural areas.

# Additional Factors to Consider Making Decision to Transition to Full/Partial Risk Financing

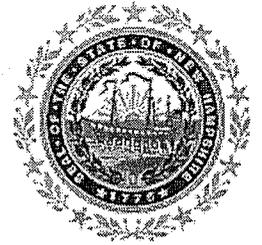


- Requires up front investment including claims run out period. (\$85M GF).
- Enrollee access to primary care providers & specialists is highly dependent on the MCO provider network & reimbursement rates.
- Cost containment efforts can result in decline in quality of care if payments to MCOs are not tied to performance & quality measures.
- Significant federal regulations for capitated managed care program.
- Contract with MCO still requires administrative resources to perform fiduciary, reporting, and quality oversight functions.
- Need to explore other options given that NH Medicaid has been engaged in managing care for a number of years.

# NH DHHS Objectives In Considering Next Steps



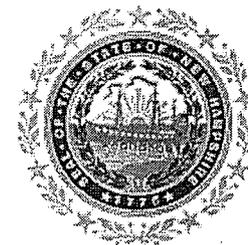
- Improve beneficiary health and/or prevent further deterioration in health status.
- Reimbursement for effective and efficient health care through payment for improved health outcomes thereby maximizing the value of each dollar spent on the care of Medicaid beneficiaries.
- Support continuity of care *through* coordination across all DHHS and medical systems of care including state plan, behavioral health and long-term care waiver services.
- Assuring timely access to preventive care.
- Assuring the appropriate site of service.
- Preventing avoidable admissions and readmissions.
- Promote shared decision making.
- Improved budget predictability
- Consider longer term 2014 Medicaid expansion.



# NH Medicaid's Next Steps...

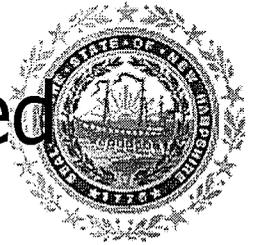
- Focus on the design, development, and implementation of reimbursement strategies for/to support a comprehensive managed care health care delivery system.
- SB 147-FN: Mandatory Medicaid Managed Care
  - An instrument supporting the change DHHS is seeking.
  - DHHS has suggestions to further refine the bill as it makes its way through the legislative process to ensure that it best meets the needs of the NH Medicaid program.

# Maine's Implementation Cost Estimates



Task	Match	Yr 1 Planning General Funds (000's)	Yr 1 Planning Total (000's)
Stakeholder engagement	50/50	\$ 250	\$ 500
Model design	50/50	\$ 250	\$ 500
State Plan Amendments/Waivers	50/50	\$ 250	\$ 500
RFP; Issue & Evaluate	50/50	\$ 250	\$ 500
Actuarial rate development	50/50	\$ 375	\$ 750
Information Systems Updates	90/10	\$ 100	\$ 1,000
Quality Program Development	50/50	\$ 240	\$ 480
Enrollment Broker	50/50	\$ 125	\$ 250
Contract Development/Management	50/50	\$ 125	\$250
<b>TOTAL Implementation Costs, FY 11</b>		\$ 1,965	\$ 4,650
Reallocation of existing contract & staffing resources	50/50	(\$ 425)	(\$ 850)
<b>Net New Needs, FY 11</b>		\$ 1,540	\$ 3,800

# Maine's Illustrative Ongoing Managed Care Operational Costs



Tasks	State Resources	Outside Resources	Match Rate	State Funds (000's)	Total Funds (000's)
Define Operational Model	√	√	50/50	\$ 150	\$ 300
Stakeholder Engagement	√	√	50/50	\$ 50	\$ 100
Development & Submission of State Plan Amendment/Waiver	√	√	50/50	\$ 50	\$ 100
Rate Development		√	50/50	\$ 125	\$ 250
Additional Operational Updates	√	√	75/25	\$ 50	\$ 200
External Quality Review Organization (EQRO)	√	√	60/40	\$ 140	\$ 350
Enrollment Broker		√	50/50	\$ 50	\$ 100
Contract Development & Management	√		50/50	\$ 100	\$ 200
<b>Subtotal annual operational costs</b>				\$ 715	\$ 1,600
Savings on existing care management, assessment and utilization review				(\$ 2,100)	(\$ 6,300)
<b>Net annual operational savings</b>				(\$ 1,385)	(\$ 4,700)