Medicaid Comprehensive Waiver – Special Terms and Conditions

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MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
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The Comprehensive Waiver's background

- The Medicaid Comprehensive Waiver was submitted in September 2011
- Face to face meeting held with CMS in February 2012
- Received a letter of Agreement in Principle from CMS as a result of that meeting in February 2012
- Steering Committees and working groups have been convened for the various delivery system reforms
- Finalizing the Special Terms and Conditions which includes Budget Neutrality

What are Special Terms and Conditions (STCs)?

- The Special Terms and Conditions (STCs) is the contractual agreement between the State of New Jersey and the Centers for Medicare and Medicaid Services (CMS). The STCs set forth conditions and limitations on waiver and expenditure authorities and describe the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration

STC Overview

The current draft STCs have 22 sections which include:

- Preface
- Program Description and Historical Context
- General Program Requirements
- Eligibility
- Benefits
- Cost Sharing
- Delivery System I – Managed Care Requirements
- Delivery System II – Additional Delivery System Requirements for Home and Community Based Services and Managed Long Term Services and Supports
- Delivery System III – Behavioral Health
- Transition Requirements for Manage Long Term Services and Supports
- New Home and Community Based Service Programs
- Premium Assistance
- Quality
- Funding Pools
- General Reporting Requirements
- Administrative Requirements
- General Financial Requirements under Title XIX
- General Financial Requirements under Title XXI
- Monitoring Budget Neutrality for the Demonstration
- Evaluation and Design
- Scheduled Deliverables
- Additional Attachments

Key Waiver Features

Delivery System Reform

Three sections of the STCs deal with the delivery system reform:

1. Delivery System I – Managed Care Requirements
2. Delivery System II – Additional requirements for HCBS and MLTSS
   - Transition requirements for MLTSS
3. Delivery System III – Behavioral Health

Managed Care Requirements

- Includes standard contractual requirements including:
  - Network requirements
  - Network adequacy
  - Provider credentialing
  - Mandatory enrollment
  - HMO choice
  - 10-day selection

Additional Requirements for HCBS and MLTSS

- Implementation for MLTSS is scheduled for January 1, 2013 or upon readiness.
- Requirements include:
  - Home and Community Based Characteristics
  - Health and Welfare of Enrollees through the use of a Critical Incident Management System
  - Participant protections
  - Grievance and Complaint System
  - Access to Fair Hearings
  - Plan of Care (PoC)

Transition requirements for MLTSS

- Requirements include:
  - Transitioning 4 HCBS waiver programs – notice must be sent to program participants 30 days prior to implementation
  - Readiness review requirement – state must begin readiness with each HMO 90 days prior to implementation and submit the readiness plan to CMS 30 days prior to implementation.
  - Requires for a period of time DMAHS have a steering committee to address MLTSS implementation and operational issues

Behavioral Health

- Effective July 1, 2013 or upon readiness adults will have their behavioral health coordinated by a Behavioral Health ASO
  - The BHO will be contracted on a non-risk basis as an ASO.
  - Exceptions may include: duals eligibles enrolled in a SNP and individuals in need of LTSS/HCBS services . In most of those cases, behavioral health will be coordinated and reimbursed by one of the Medicaid MCOs.
  - Should the State decide to implement an at-risk arrangement for the BHO the State must submit an amendment to CMS.

New HCBS programs

- The Comprehensive Waiver authorizes new HCBS programs that will remain outside of MLTSS, they include:
  - The Supports Program
  - Children with Pervasive Developmental Disorders (PDD)
  - Children with intellectual Disabilities with co-occurring mental illness
  - Persons with intellectual disabilities who live out of state
  - Children with Serious Emotional Disturbance (SED)
  - Medication Assisted Treatment Initiative (MATI)
- We anticipate January 1, 2013 start dates except for MATI which will coincide with the BH ASO July 1, 2013

Quality Strategies

- CMS requires quality strategies for all MLTSS and HCBS programs.
- A quality strategy for behavioral health, managed care and MLTSS measures is due to CMS 90 days prior to implementation
- Quality strategies for the new HCBS programs are due 60 days prior to implementation
- Content of the quality strategies must include:
  - The application of a continuous quality improvement process
  - Representative sampling methodology
  - Frequency of data collections and analysis
  - Performance measures
- Working with the Human Services Research Institute (HSRI) for technical assistance in developing the quality strategies

Evaluation plan

- 1115 waivers are 5 year demonstrations therefore an evaluation plan is required.
- The state must develop a draft evaluation design for an overall evaluation of the demonstration 120 days after approval of the demonstration.
- The draft design should include:
  - Goals, objectives and specific hypotheses that are being tested
  - Outcome measures that will be used and the data sources and methodology for assessing these outcomes

Waiver Status

- STCs are being finalized
- Outstanding issues include: Budget Neutrality and Hospital Funding Pools

New Jersey Medical Assistance Advisory Council (MAAC)

Managed Long-Term Services and Supports Steering Committee Recommendations Report

June 25, 2012

Kathy Mason
Assistant Commissioner
New Jersey Dept. of Health & Senior Services

New Jersey Managed Long-Term Services and Supports
Agenda

- New Jersey's Managed Long-Term Services and Supports (MLTSS) Guiding Principles
- Steering Committee Membership
- Frequency and Scope of Meetings
- Outside Experts Consulted
- Recommendations by Workgroup
- Questions

Workgroup
Overview

Guiding Principles

- New Jersey's overall goal is to provide quality long-term services and supports to individuals of all ages in the most integrated setting appropriate to their needs. New Jersey will build a system that is cost effective and sustainable for the future
  - Home and Community-Based Services (HCBS) is the preferred service delivery method for people receiving MLTSS
    - Access to a broad array of coordinated services and options should be provided so as to enable people to make informed choices about how and where they live and to reduce the need for institutional care;
    - Person-centered service options should be available so that individuals of all ages who use MLTSS are enabled to live in the community, in their own homes if possible;
    - Criteria for community living should include: privacy; autonomy; respect; personal preference; cultural differences; dignity; safety; choice and control within the residential setting; integration with the greater community; independent advocacy when appropriate; and personal control over moving to, remaining in or leaving the setting; and
    - Nursing Homes will remain an essential component of the continuum of MLTSS. Working collaboratively with the industry and other stakeholders, the State must consider the future of nursing homes that offer quality care in a home-like environment and that honors the residents' preferences and cultural differences.

Guiding Principles (cont'd)

- Consumer choice and participation in selecting service providers and living settings, to the maximum extent feasible, should be a priority of New Jersey's MLTSS
  - People of all ages have the right to choose and, if they wish, direct their care plan;
  - MLTSS will work with individuals to ensure that quality of life is as important as quality of care;
  - MLTSS will work to maintain or improve the health and functional status of seniors and people with disabilities; and
  - Easy to understand, complete, up-to-date and accurate information will be provided to individuals and their caregivers.

- Participation of all stakeholders in the planning and implementation of MLTSS
  - The State of New Jersey will establish an ongoing stakeholder input process; and
  - Development of transparent quality measurements is needed, with input from stakeholders, that emphasize quality of life outcomes and consumer empowerment and choice.

Steering Committee Membership

- Medicaid Long-Term Care (LTC) Funding Advisory Council of New Jersey, Managed Care Organizations (MCOs) and Consumers

  - **Sherl Brand,** Home Care Association of New Jersey
  - **Frank Cirillo**, County Welfare Directors Association of New Jersey
  - **Karen Clark**, Horizon NJ Health
  - **William Cramer**
  - **James Donnelly**, New Jersey Adult Day Services Association
  - **Theresa Edelstein**, New Jersey Hospital Association
  - **Beth Eichfeld**, Lutheran Social Ministries - Life Jersey City
  - **Scott Elliot**, Progressive Center for Independent Living
  - **Eli Feldman**, Metropolitan Jewish Health System
  - **Kathy Fiery**, Assisted Living, Health Care Association of New Jersey
  - **Deborah Hammond**, HealthFirst
  - **Michele Kent**, LeadingAge New Jersey
  - **John Kirchner**, HealthFirst

Steering Committee Membership (cont'd)

- Medicaid LTC Funding Advisory Council of New Jersey, MCOs and Consumers

  - **John Koehn**, Amerigroup Corporation
  - **Paul Langevin**, Health Care Association of New Jersey
  - **Susan Lennon**, New Jersey Association of Area Agencies on Aging
  - **Evelyn Liebman,** AARP New Jersey
  - **Andrew McGeady**
  - **Charles Newman**, New Jersey Association of County Disability Services
  - **Barbara Geiger-Parker**, Brain Injury Alliance of New Jersey, Inc.
  - **Marsha Rosenthal**, Rutgers University Center for State Health Policy
  - **Lorraine Scheibener**, Warren County Division of Temporary Assistance and Social Services
  - **Milly Silva**, SEIU local 1199 New Jersey
  - **Michael Simone**, United HealthCare
  - **Deborah Spitalnik**, Boggs Center on Developmental Disabilities, UMDNJ-Robert Wood Johnson Medical School

Frequency and Scope of Meetings

- Meetings began in March 2012
  - Workgroups met on a bi-monthly basis, at a minimum, to finalize recommendations
  - Gathered reports, analyses and heard outside expert presentations
- Goals
  - Broad stakeholder participation
  - Framework for discussion and learning and to share best practices from other states, CMS and professional/academic organizations
  - Capture diverse and all encompassing feedback from stakeholders to formulate workgroup recommendations

Outside Experts Consulted

- The Center for Health Care Strategies (CHCS)
  - CHCS is a non-profit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.
- Mercer Human Services Consulting (Mercer)
  - Specializes in assisting government-sponsored programs in becoming more efficient purchasers of health and welfare services. Mercer brings a team of consultants, clinicians, actuaries, analysts and accountants to a project to ensure a coordinated approach to the administrative, operational, actuarial and financial components of public-sponsored health and welfare programs.

Workgroup
Recommendations

Assuring Access Recommendations

- Continue work on consolidating service definitions and establishing standardized codes
- Identify service gaps through stakeholder surveys and using provider licensing data
- Use gap analysis to determine network requirements for high-usage and low-usage services and identify any barriers to access
- Streamline credentialing
- Require continuity of care provisions
- Special enrollment period for PACE and MCOs at implementation of MLTSS and at NF LOC determination

Assuring Access Recommendations (cont'd)

- Support nurse delegation of medication administration through regulation and then reimbursement changes
- One government entity responsible for resource directory
- All points of contact with consumers should be culturally and linguistically sensitive, and methods of collecting information should be examined
- Determine where prior authorization processes may be standardized
- Training on MLTSS services and eligibility for all points of contact with consumers; deliver ongoing education for direct support staff

Assessment to Appeals Recommendations

- Role of ADRC - Single entry/no wrong door, options counseling, assist with Medicaid application
- NJ Choice Assessment Tool, NF LOC conducted by MCO/State
- Clinical Eligibility and Options Counseling will be completed within two weeks of referral/notification for PAS and Level 1 PASRR Screen and if needed, Level II PASRR Review
- Options Counseling training curriculum and certification developed by the State for ADRC, SHIP, State Assessors, MCO and PACE
- Waiver of Eligibility for certain diseases/conditions, deeming when person's NF LOC is dependent upon MLTSS
- Facilitate financial eligibility within 45 days (under the age of 65 - 90 days to determine financial eligibility per the CMS 45/90 day rule)
- Care management competence standards to ensure complex care needs are met

Assessment to Appeals Recommendations (cont'd)

- Integrate behavioral health, primary, acute and MLTSS
- Transition care management caseloads
- Clear delineation between organizational units to ensure conflict free care management
- Identify and coordinate NF transition members/MFP and ensure a safe transition to the community
- Address health and safety concerns - partner with APS, OPG, DCF, ombudsman
- Revise Appeal Rights and Fair Hearing Policies where needed
- Ensure that individuals receiving HCBS services have access to an independent advocate

Provider Transition Recommendations

- Any willing provider/any willing plan for NF, SCNF, AL and LTC pharmacies
- Use State reimbursement rates for NF and AL for 2 years
- Use current clinical eligibility process and FY 12 rate (with some carve-outs) for SCNF for 2 years
- Timely payment of NF, SCNF, PMDC and ADHS claims
- Continuity of care for NF and AL patients for the duration of their residency
- Standardize billing processes where possible

Provider Transition Recommendations (cont'd)

- 5 month provider training and 3 month provider claims testing
- MCO MLTSS claim help specialist
- Research electronic visit verification system
- NF LOC redetermination
- MCO based Advisory Group on MLTSS
- Gap Payment Methodology after AWP period

Quality and Monitoring Recommendations

- 18 Guiding Principles
  - Transparency
  - Accountability
  - Consistent approach
  - Monitoring quality
  - Use of benchmarked metrics
  - Quality of Life/Quality of Care
  - Avoid duplication and administrative complexities in data definitions and collection
  - Consumer empowerment and choice
  - System rebalancing and community-based care solutions

Quality and Monitoring Recommendations (cont'd)

- 18 Guiding Principles
  - Prevention, wellness and independence
  - Promote continuous quality improvement
  - Diversity, cultural competence and health literacy
  - Address the needs of consumers across the life span
  - Improved Information Technology
  - Leverage technology for quality and monitoring
  - Identify the "Lead" in MLTSS
  - Keep system capacity and resources in mind
  - Care/Case Management

Quality and Monitoring Recommendations
Domains for Outcome Measures of a High-Performing System

- Quality monitoring and improvement is dependent upon a robust system that uses benchmark metrics; supports data driven decision making; avoids duplication and administrative complexity; promotes continuous quality improvement

1. **Health & Safety** - Health and Safety including backup plans, crisis management and critical incident reporting is addressed.
2. **Personal Preferences and Consumer Choice** - A high-performing system uses a person-centered approach to MLTSS and places high value on allowing consumers to exercise choice and control.
3. **Access** - MLTSS is accessible at all levels of health literacy and promotes cultural and linguistic competence.
4. **System Balance Institutional and HCBS** - Continually monitors rebalancing from institutional-based care to HCBS, promotes Money Follows the Person principles, seamless Nursing Facility Transitions and Diversions.
5. **Transitions & Organization of Care** - MLTSS is effectively coordinated with integrated health related measures including medical and social supports.

Quality and Monitoring Recommendations (cont'd)
Domains for Outcome Measures of a High-Performing System

6. **Quality of Care** - Supports individualized health care that is focused on prevention, wellness, reducing readmissions.
7. **Care Management** - Robust care management system across service systems that has coordination and collaboration as essential functions.
8. **Provider Networks** - Adequate networks for HCBS and alternative services, qualified workforce and stable workforce.
9. **Services** - Promotes innovative and flexible service options, including non-traditional supports.
10. **Quality of Life Across the Lifespan** - Offers the right care at the right time in the right place/setting across the life span.
11. **Family Caregiver Supports** - Offers family caregivers the appropriate supports, education and skills to be able to assist the MLTSS member.

QUESTIONS?

Medicaid Comprehensive Waiver Behavioral Health Stakeholder Steering Committee Report Presentation

JUNE 25, 2012

AN OVERVIEW OF THE REPORT

- Acknowledgements
- Executive Summary
- The Stakeholder Steering Committee
- Guiding Principles
- Recommendations
  - Access
  - Clinical
  - Fiscal
  - Outcomes
- Attachments

EXECUTIVE SUMMARY

- Includes:
  - An overview of the Waiver application reform goals
  - A detailed summary of the behavioral health system improvements and innovations included in the waiver
  - A narrative description of the Stakeholder Steering Committee and Work Group charge to provide recommendations to DMHAS and DMAHS
  - A description of the Work Group process and timeline

EXECUTIVE SUMMARY

- The Work Groups were asked to embrace a consumer-centered, wellness and recovery orientation and to keep key consumer-level and systems level considerations in mind as they engaged in their work.
- Each Work Group was asked to prepare a report that identified key issues for consideration, challenges and opportunities, and recommendations for the Steering Committee within their respective areas of focus.

EXECUTIVE SUMMARY

- Certain fundamental goals were expressed across all four Work Groups:
  - Improve access to behavioral health care
  - Integrate care for consumers with behavioral and physical health conditions
  - Improve consumer health outcomes and satisfaction
  - Maximize available resources to achieve the first three goals.
- The Steering Committee developed a set of guiding principles to inform the design and implementation of a managed behavioral health system of care.

STAKEHOLDER STEERING COMMITTEE

- DMAHS Director Valerie Harr and DMHAS Assistant Commissioner Lynn Kovich provided an overview of the purpose and goals of the Stakeholder Steering Committee:
  - to inform the DHS' values and vision regarding the design and implementation of the ASO/MBHO;
  - to elicit broad stakeholder input regarding the design and development of the various components of the ASO/MBHO;
  - to initiate a small group process to inform at a more detailed level the components of the ASO/MBHO; and
  - to identify and leverage opportunities under Health Care Reform to support a transformed system.

STAKEHOLDER STEERING COMMITTEE

- The Work Groups were asked to embrace a consumer-centered, wellness and recovery orientation and to keep key consumer-level and systems level considerations in mind as they engaged in their work.
- Each Work Group was asked to prepare a report that identified key issues for consideration, challenges and opportunities, and recommendations for the Steering Committee within their respective areas of focus.

GUIDING PRINCIPLES

- The ASO/MBHO must be person-centered, reflecting the strengths, resources, challenges, and needs of consumers.
- The system needs to be easy for consumers and families to access and use. It is critical to ensure that the ASO/MBHO itself does not create additional barriers for consumers seeking to access services.
- The State should pursue reimbursement rates at levels that will induce a sufficient number of providers to enter the marketplace to deliver necessary services to consumers, while meeting availability, access, geography and quality objectives and regulatory requirements.
  - Financial and non-financial incentives need to be established to build a system that supports the over-arching principles of wellness and recovery, while tracking monitoring utilization and costs across the continuum of care to ensure that resources are expended efficiently and desired outcomes are achieved.

GUIDING PRINCIPLES

- The ASO/MBHO design should be informed by the fundamental belief that with services and supports consumers can manage their behavioral health conditions while regaining and sustaining purposeful and meaningful lives.
  - This should be reflected in the system design by emphasizing the integration of primary and behavioral healthcare services managed by the ASO/MBHO and the Medicaid managed care organizations (MCOs) to promote holistic, community-based care for the purpose of overall consumer wellness and recovery.
  - The transformation of the behavioral health system of care from an unmanaged, cost-related contracting system to a managed system that purchases services on a fixed-rate, fee-for-service basis is a challenging step towards creating an environment where consumers receive appropriate care and supports in a manner that is efficient, accountable, and affordable to the taxpayers.

GUIDING PRINCIPLES

- While the implementation of the ASO/MBHO is anticipated to achieve improved behavioral health quality and outcomes, and contain costs, government, community, and constituent stakeholders should be cognizant that many desirable outcomes will not be fully realized without a commitment to collaboration and accountability shared by other systems that also engage and serve behavioral health consumers including other programs and services administered by DHS, the Departments of Health and Senior Services and Labor and Workforce Development, as well as the judiciary and criminal justice systems.

CHARACTERISTICS OF AN ASO/MBHO

- The following were identified by the Work Groups as characteristics an ASO/MBHO should possess in order to reflect the values of New Jersey's behavioral health system. The ASO/MBHO needs to:
  - Have the capacity to serve individuals with complex behavioral, medical, and/or social needs, including those with co-occurring mental illness, substance use disorders, and intellectual and developmental disabilities. These individuals should be provided with the support necessary to navigate the system in order to address all their needs.
  - Provide a seamless service delivery system that facilitates coordination, communication, and collaboration between partners.
  - Utilize quality improvement strategies that interface between DHS, the ASO/MBHO, providers, and consumers and reflect consumer, family, and stakeholder participation.

CHARACTERISTICS OF AN ASO/MBHO

- Ensure the delivery of high quality services under the ASO/MBHO by a trained and competent workforce.
- Easily exchange information and use that information to provide coordinated services.
- Support technological interoperability and quality improvement functions.
- Adhere to documentation requirements that inform clinical decision-making and support the clinical process.
- Maintain transparency with respect to data regarding both ASO/MBHO and provider performance.
- Recognize that the need to maintain safety is of paramount importance for consumers, families and staff.
- Have a New Jersey location for all direct operations including care management, prior authorization, clinical, and phone/help desk operations.

ACCESS WORK GROUP RECOMMENDATIONS

- The Access Work Group developed a set of recommendations for access requirements to be included in the Request for Proposals (RFP) that will be issued to procure the ASO/MBHO.
- These recommendations describe what the ASO/MBHO should demonstrate and specify in their response to the RFP with respect to the following areas:
  - Capacity and Service Delivery
  - Care Coordination and Continuity of Care
  - Information and Education
  - Ease of Initial Access
  - Geographic Proximity
  - Timeliness of Access
  - Cultural and Linguistic Competence
  - Complex Behavioral, Medical and Social Needs

CLINICAL WORK GROUP RECOMMENDATIONS

- Ensure that the system provides for the consumer to have a positive experience of care. This includes but is not limited to: easy access, effective care, adequate measures of safety, easy appeals process, and help with immediate needs.
- Services should be client directed whenever possible. For example, the system should include a client directed comprehensive care and crisis plan that can move to and from agencies to follow the consumer through the system that includes psychiatric advanced directives.
- Provisions to ensure the safety of consumers, staff and the public must be included in the design and supported by funding.
- Workforce development is critical to effective and efficient service delivery and should be supported and funded by the division.
- The system should provide the right service for the right person in the right dose at the right time. This would include, but is not limited to, prevention services, services designed to divert consumers from high-end care, easily accessible screening with full assessment completed by credentialed professionals, funded services to engage consumers in care, and uniform placement criteria across the system.

CLINICAL WORK GROUP RECOMMENDATIONS

- Integrate mental health and addiction services so that there is “no wrong door’ and effective services are readily available for consumers with mental illness, addiction and co-occurring illness
- Provide the services providers with the support and funding necessary to maintain and improve system capacity. Some examples are: align provider regulations across systems, continue provider ability to meet the basic needs of consumers when necessary, fund providers to be accessible 24/7, and enhance services for individuals with complex needs such as I/DD consumers, aging out consumers and those that are justice involved.
- Integrate physical and behavioral health services to reverse health disparities and the premature deaths of our consumer.s
- Utilize technology to increase the system effectiveness, cut costs and improve consumer experience of care.

FISCAL WORK GROUP RECOMMENDATIONS

- Provided recommendations for a seamless, user-friendly service authorization and claims processing system
- Prioritized the services in the behavioral health system to target for rate rebalancing
- Provided reasonable options for a transition from cost reimbursement to FFS provider contracts
- Suggested payment strategies that will incentivize provision of good care for reasonable cost

OUTCOMES WORK GROUP RECOMMENDATIONS

- The ASO/MBHO should collect and report on outcomes that reflect the Work Group's quality improvement framework (attached as an appendix to the final report) as a baseline
- Consider the interrelationship of outcome and process measures to evaluate performance
- Conduct a practical and meaningful consumer/family satisfaction/perception of care data collection and evaluation process
- Evaluate and implement the use of incentives and penalties
- Align outcome measures with Federal and other regulatory bodies as well as other states
- Performance benchmarks should be used from existing industry data with consideration of the NJ specific data as the system matures
- Existing or readily obtained data should be utilized to limit the burden of data collection

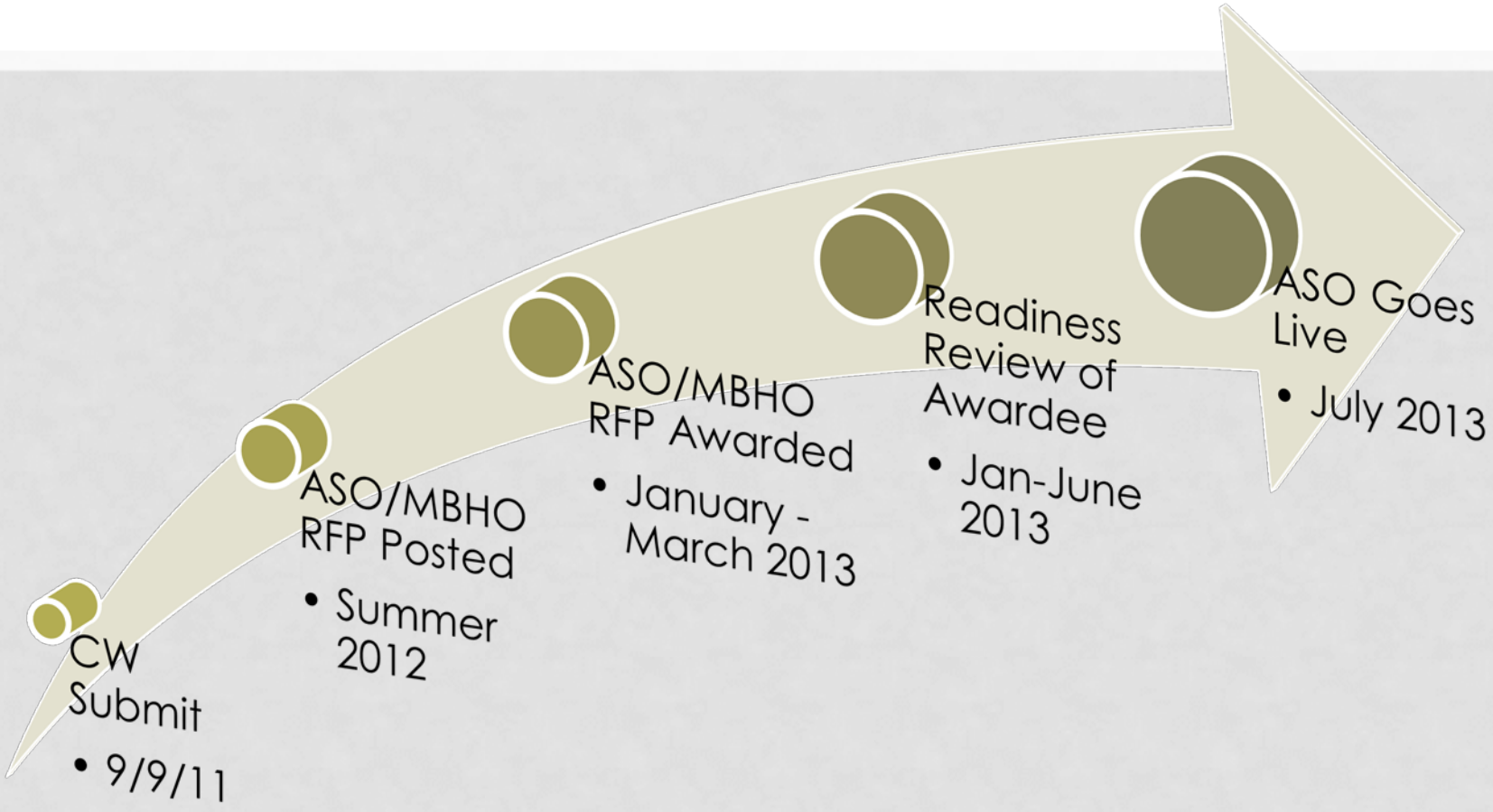
OUTCOMES WORK GROUP RECOMMENDATIONS

- Outcomes should reflect a wellness and recovery based approach
- Implementation of evidence based and emerging practices is reinforced through monitoring and quality improvement
- Effective coordination of care is a desired outcome at the individual and the systems level
- Quality improvement priorities may change over time due to emerging needs and unanticipated occurrences
- Identify safeguards that ensure the most effective treatment and not just the most inexpensive treatment is delivered
- Recognize that some desirable outcomes, such as employment, may be outside the scope of the ASO/MBHO
- Stakeholder must be engaged in each step of the quality management process
- ASO/MBHO applicants should be required to demonstrate their capacity for delivering a robust quality management (QM) program, including but not limited to: staff and technology to support data analytics, consumer and other stakeholder involvement in QM activities, and proven strategies to ensure transparency of QM information

ATTACHMENTS TO THE REPORT

- Access Work Group Attachment
  - Access Work Group ASO Map
- Clinical Work Group Attachment I
  - Recommended Services Array
- Clinical Work Group Attachment II
  - Case Management Existing Services
- Clinical Work Group Attachment III
  - Case Management Proposed Services
- Outcomes Work Group Attachment I
  - Quality Improvement Framework
- Outcomes Work Group Attachment II
  - Guiding Principles

TIMELINE


CW Submit
• 9/9/11
ASO/MBHO RFP Posted
• Summer 2012
ASO/MBHO RFP Awarded
• January - March 2013
Readiness Review of Awardee
• Jan-June 2013
ASO Goes Live
• July 2013