HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 26, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

HMA TELEHEALTH SERIES: TELEPSYCHIATRY AND THE PSYCHIATRIC WORKFORCE SHORTAGE

This week, our *In Focus* section is the second in an ongoing series of HMA telehealth features. HMA principal Lori Raney, MD, provides an overview of telepsychiatry, a type of telemedicine where general psychiatric services are provided via videoconferencing, and how it can play a role in addressing the nationwide psychiatric workforce shortage. Dr. Raney highlights the opportunities for telepsychiatry in the market today, as well as identifies several of the obstacles to telepsychiatry implementation.

The Psychiatric Workforce Shortage

One in five people in the US will experience a behavioral health condition in their lifetime yet only 40 percent will receive any form of treatment. Behavioral health conditions and their impact on overall health outcomes and utilization have become a major focus for health care systems, and significant federal, state and private funding have been directed towards finding adequate and timely treatments. With behavioral health conditions now clearly recognized as contributing to a two to three fold increase in overall health care costs, and value-based payments and the Medicare Access and CHIP Reauthorization Act (MACRA) on the horizon, better solutions for timely and effective behavioral health care are needed now. In addition, health care reform efforts, including Medicaid expansion and the gradual reduction in stigma associated with having a behavioral health condition, have led to record numbers of people seeking treatment.

One of the obstacles to providing effective care is the shortage of psychiatrists, which has been an ongoing issue for several decades. Although efforts to increase the number of medical students selecting to train in psychiatry have been tried, this has not resulted in any significant increase due in part to low salaries and professional stigma. The shortage is further exacerbated by the desire for psychiatrists, like other specialty physicians, to live in more urban areas, leading to a geographical maldistribution of the workforce. Further complicating the problem is the fact that over half the psychiatrists in the country are over the age of 55 and looking at retirement in the next decade.

In more rural areas the situation is quite dire with 50 percent of counties without any behavioral health providers in any discipline and 95 percent of counties with a severe shortage of experts in prescribing psychotropic medications. This perfect storm of short supply and rising demand is hitting at a time when reform efforts desperately need innovative solutions.

Overview of Telepsychiatry

Telepsychiatry is a type of telemedicine where general psychiatric services are provided via videoconferencing. The service has been used for more than two decades. However, there was minimal uptake until the past several years when two things occurred; first, rising numbers of largely younger psychiatrists started to choose telepsychiatry as a predominant way to practice medicine, and second, the cost of technology to deliver the service declined dramatically. The growing trend has spawned the proliferation of over 30 companies now operating in this space with some companies reporting more psychiatrists applying than there are available positions. Telepsychiatry is being implemented in diverse locations including:

- community mental health centers
- primary and specialty care settings
- skilled nursing facilities
- emergency rooms
- correctional settings, and
- inpatient hospital sites.

In settings that have psychiatrists, it is being utilized to cut down on "windshield time" spent travelling across town or to satellite clinics, increasing appointment availability.

Telepsychiatry does not address the psychiatrist shortage per se as it does not add more psychiatrists to the overall pool. Instead, it offers a solution to the geographic maldistribution of the workforce allowing staff from more urban areas to beam into rural communities electronically. In addition, there is a growing trend in using telepsychiatry to also deliver consultative services in addition to direct care. This population-based approach, where the psychiatrist assists and supports other providers (such as primary care providers) in the treatment of mild to moderate behavioral health conditions, leverages scarce psychiatric resources to cover larger populations of those in need. One particular approach to this type of consultative service that could be adapted to telepsychiatry, known as the collaborative care model, has recently been selected by the Center for Medicare and Medicaid Services to be reimbursed in the 2017 Physician Fee Schedule after demonstrating robust results in a recent Center for Medicare and Medicaid Innovation (CMMI) grant-funded opportunity.

Telepsychiatry has an evidence base demonstrating:

- it is comparable to in-person psychiatric care
- it can reduce overall health care costs
- it is widely accepted by patients and providers, and
- direct-to-consumer care is a growing trend with many organizations already providing this service.

Challenges in Telepsychiatry Market

Barriers to implementation include funding and regulatory limitations that vary state to state, mostly due to outdated beliefs about telemedicine being less effective than direct evaluation or that the patient must receive telepsychiatry services in a medical clinic exclusively. Many states have current legislative agendas to remedy these limitations in order to meet the behavioral health needs of their population. Interstate physician licensure requirements stipulate the provider must have a license in the state where the patient resides, a process which can take 3-6 months to complete for an out-of-state physician. National organizations are working to push for changes and offer resources including readiness assessment tools and implementation guides. Some payers have required patients be physically located in clinic sites while others have offered lower reimbursement when services are delivered electronically. However, as acceptance of telepsychiatry has grown and demand for psychiatric services has continued to increase, changes in reimbursement practices have quickly followed.

Telepsychiatry, like all forms of medical care, requires careful selection of providers and telepsychiatry vendors. Understanding local internet capability and problem-solving bandwidth issues is important to success. Planning and adequate preparation for introducing any new model of care takes time and effort, and organizations looking for solutions to address their psychiatric behavioral health care needs with this modality should think of implementation as they would with any change management initiative.

For More Information

For questions or information on this brief, please contact Lori Raney, MD, at lraney@healthmanagement.com. Dr. Raney is a psychiatrist and Master Trainer in the collaborative care model of integrated care and its adaption to telepsychiatry.

HMA Medicaid Roundup

Arizona

Governor Orders Medicaid, State Employee Insurance to Limit Opioid Prescriptions. The *AP/azcentral.com* reported on October 24, 2016, that Arizona Governor Doug Ducey signed an executive order limiting Medicaid and the state employee insurance plan opioid prescriptions. Initial prescriptions will be limited to a seven-day supply for adults and children unless they the patient is receiving treatment for cancer, chronic disease, or traumatic injury. The order is an effort to cut drug addiction. Governor Ducey also announced that individuals on state-funded plans will not need pre-approval for Vivitrol, which is prescribed to individuals in treatment for opioid addiction. Earlier this year, the Governor signed a law requiring doctors to check a database before prescribing narcotics to patients. Read More

Arkansas

Provider-Led Medicaid Managed Care Model Proposed for Older Adults, Individuals with Disabilities. *ArkansasOnline* reported on October 25, 2016, that Arkansas has renewed efforts to pursue Medicaid managed care for older adults and individuals with long term care needs, including individuals with physical disabilities and individuals with intellectual or developmental disabilities. However, the latest proposal, presented to the Arkansas Health Reform Legislative Task Force on October 23, would feature provider-led managed care organizations, similar to models in Colorado or Oregon. These provider-led coordinated care organizations would contract with regional provider networks to share information and cut costs. The proposal would potentially generate millions of dollars in revenue through an insurance premium tax. Read More

Colorado

Universal Health Care Proposal Prospects Uncertain as Ballot Vote Approaches. *The New York Times* reported on October 25, 2016, that the $25 billion-a-year Colorado universal health care proposal faces uncertain odds in the upcoming ballot vote. The plan would implement a new 10 percent payroll tax to replace premiums and employer-subsidized insurance. However, the proposal has faced opposition from insurers and other opponents, who have spent over $3 million to campaign against the proposal. Many individuals still question what the exact cost will be and what coverage would ultimately look like. Read More

District of Columbia

Top Health Care Official to Manage Kaine Transition Team. *The Washington Post* reported on October 22, 2016, that Wayne M. Turnage, the Director of the District of Columbia Department of Health Care Finance, which oversees the District's Medicaid program, will be Tim Kaine's transition manager if the Clinton-Kaine ticket wins the White House in November. Turnage was chief of staff to Kaine from 2006 to 2010, during his term as Governor of Virginia. Read More

Idaho

Legislative Committee to Submit Report of Medicaid Expansion Options for 2017 Session. *The Daily Progress* reported on October 24, 2016, that an Idaho legislative interim committee submitted Medicaid recommendations to be considered during the 2017 legislative session. The 10-member group could not come to a consensus on how to best provide coverage for the roughly 78,000 uninsured Idahoans who could be covered through expanding Medicaid. Instead, the committee is finalizing a report detailing potential coverage options in a report to be submitted November 22 as a guide for future proposals. The list included traditional Medicaid expansion, a grant program covering primary care services to the Medicaid gap, and Medicaid expansion with the private sector covering state costs. Read More

Indiana

HMA Roundup – Pat Casanova (Email Pat)

Medicaid Non-Emergency Medical Transportation RFP Issued. Indiana released a request for proposal on October 20, 2016, for non-emergency medical transportation (NEMT) for the state's fee-for-service Medicaid program. The winning bidder will act as broker and administrator of the program. A pre-proposal conference will be held October 31, 2016 at 2:00 pm. Proposals are due December 15, 2016, with awards expected February 28, 2017. To access the RFP and related documents, click here.

Kansas

CMS Questions Disability Support Service Policy Changes. *Kansas Health Institute* reported on October 24, 2016, that the Centers for Medicare and Medicaid Services (CMS) has requested additional information and feedback from the Kansas Department on Aging and Disability Services (KDADS) on several policy changes made to the state's home and community-based disability support services program as part of an effort to balance the state budget. CMS is seeking information regarding the state's decision in August to eliminate a waiting list for individuals with physical disabilities. A spokeswoman for KDADS said that the state already provided CMS with extensive documentation. Read More

Kentucky

CMS Extends 1115 Waiver Proposal Comment Period. *Modern Healthcare* reported on October 20, 2016, that CMS will extend the comment period for Kentucky's 1115 Medicaid waiver proposal, Kentucky Health. The proposal, which has received nearly 1,800 comments, would add job requirements, cost-sharing, and six-month lockouts for missed payments. Kentucky is the first state to receive such an extension. Read More

Michigan

Senate Votes to Continue 6 Percent Medicaid MCO Tax. The *Associated Press/Chicago Tribune* reported on October 20, 2016, that the Michigan Senate voted to continue a 6 percent "use" tax on Medicaid managed care organizations. The Senate Fiscal Agency estimated that without the tax, the state would lose $256 million in fiscal 2019. The Senate also voted to end a broader health insurance tax sooner than expected. The vote came on the final day of the current legislative session. Read More

New Jersey

Increases in Emergency Room Visits Largely Attributed to Behavioral Health, SUD. *Philly.com* reported on October 25, 2016, that a New Jersey Hospital Association report shows that emergency department visits across the state increased by 7 percent between 2011 and 2015, with a 31 percent increase in behavioral health-related visits. The number of emergency department visits related specifically to substance use disorder (SUD) is up even more, increasing by 36.8 percent between 2011 and 2015. Association Director of Professional Practice Mary Ditri says emergency rooms are often safety nets for patients with behavioral health needs who lack adequate inpatient and outpatient services in their communities. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Medicaid Inflation Rate Set at 3.3 Percent. Gongwer Ohio reports the Joint Medicaid Oversight Committee (JMOC) has set the allowable inflation rate for the upcoming Medicaid budget at 3.3 percent. Optumas, the actuarial firm, presented the range of inflation from 2.8 percent to 3.8 percent. JMOC chose the midpoint of the range. This rate sets the acceptable level of inflation in the 2018-2019 biennial budget for ongoing services. It does not include funding for new policies. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Plan Protests Could Impact Managed Long-Term Services and Supports Implementation Timeline. On October 21, 2016, *The Pittsburgh Post-Gazette* reported multiple unsuccessful bidders for Pennsylvania's Department of Human Services (DHS) Community HealthChoices (CHC) managed long-term

services and supports program have filed formal protests. Kevin Hancock, chief of staff for the state's Office of Long-Term Living has publicly said that due to protests, the state is required to suspend its discussions with the three winning bidders: UPMC for You, AmeriHealth Caritas of Philadelphia, and Centene's Pennsylvania Health and Wellness. As of now, DHS has no plans to delay the scheduled start of the CHC rollout in the Southwest Zone in July 2017. Appeals to the Commonwealth's response to protests or Commonwealth Court could impact that timeline. Read More

Washington

Accountable Communities of Health Waiver Receives Preliminary Approval. *Modern Healthcare* reported on October 19, 2016, that the state of Washington received federal approval to reform its Medicaid program through an 1115 demonstration waiver, which builds on the state's existing Healthier Washington delivery system transformation effort. The state will receive up to $1.5 billion in federal funding to drive delivery system reform through incentives and expand long-term services and supports programs, among other efforts. Washington's nine existing Accountable Communities of Health (ACHs) will play a major role in implementing the state's Delivery System Reform Incentive Payment (DSRIP) project. ACHs also work with Medicaid managed care plans to expand value-based purchasing, with a target of 90 percent of Medicaid payments being value-based by the end of the five-year waiver. A supportive housing and employment services initiative under the waiver will be coordinated through exiting behavioral health organizations, Medicaid plans, and the state. Read More

National

MACPAC Public Meeting Scheduled for October 27. The October Medicaid and CHIP Payment and Access Commission (MACPAC) public meeting has been scheduled for October 27 at the Ronald Reagan Building and International Trade Center in Washington, DC. This month's agenda includes the following topics: children's coverage, disproportionate share hospital payments, Medicaid fraud control, Medicaid prescription drug cost containment, and opioid use in the Medicaid population. Read More

HHS Reports Shows Premium Increases, Fewer Insurers for 2017 Open Enrollment. *The Associated Press* reported on October 25, 2016, that a new Department of Health and Human Services report shows that premiums for Exchange plans will increase by an average of 25 percent for mid-level benchmark plans in 2017 across 39 states. Meanwhile, the total number of insurers offering Exchange plans will decrease 28 percent in 2017, from 232 to 167. The 2017 plan year open enrollment period begins on November 1. Read More

Most Unlikely to See Impact of Double-Digit Exchange Premium Hikes in 2017. *Modern Healthcare* reported on October 25, 2016, that majority of individuals purchasing coverage through the Exchanges are unlikely to be significantly impacted by the 25 percent average premium increases for 2017. According to an analysis of federally facilitated Exchanges by the U.S. Department of Health & Human Services (HHS), the average benchmark plan premium in 2017 will be $302, compared with $242 in 2016. However, most

individuals are likely to see a small increase, but not 25 percent, due to the income-based premium tax credits available to individuals who purchase coverage through a state-based or federally facilitated Exchange. An estimated three-fourths of returning customers will be able to find a plan for less than $100 a month after tax credits. Read More

2017 Open Enrollment for ACA Exchanges is Pivotal, HHS Secretary Burwell Says. *Kaiser Health News* reported on October 19, 2016, that the next open enrollment period for the Affordable Care Act Exchanges will be "pivotal," according to Sylvia Burwell, Secretary of the U.S. Department of Health and Human Services. Burwell called this open enrollment cycle, which runs from November 2016 through January 2017, a transitional period for the Exchanges. Enrollment in state and federal Exchanges is expected to grow to 12.8 million in 2017, an increase of 9 percent or 1.1 million members. Federal officials are focusing enrollment efforts on 18 to 34-year-old and people who are eligible for Exchange coverage but purchase insurance elsewhere. Read More

Nearly Half of Uninsured Eligible for Medicaid, Exchange Subsidies. The *Miami Herald* reported on October 20, 2016, that according to a Kaiser Family Foundation report, titled "*Estimates of Eligibility for ACA Coverage among the Uninsured in 2016*," approximately 12 million uninsured Americans (representing 43 percent of total uninsured) are eligible for Medicaid or federal subsidies on the health insurance Exchanges. Of these, 3.8 million are eligible for Medicaid. Ten percent of all uninsured people fall into the coverage gap because their state has not expanded Medicaid. Read More

Insurers Seek Tighter Rules on Health Insurance Exchanges. *CQ Roll Call* reported on October 21, 2016, that many health insurers are requesting tighter rules on Exchange special enrollment periods, as well as the elimination of grace periods for individuals who do not pay their premiums. Insurers suggested these and other changes in their comments to proposed 2018 Exchange rules released in August by the U.S. Department of Health & Human Services (HHS). While the proposed rules were largely praised by insurers, many are pushing for additional changes in hopes of strengthening the Exchange market, which saw a number of insurer exits for the 2017 plan year.

Industry Research

Studies Show Potential of Mental Health Courts to Slow Rate of Incarceration. *Kansas Health Institute* reported on October 25, 2016, that several research studies in the U.S. have shown that mental health courts, which aim to help individuals receive treatment as an alternative to jail, could decrease the rate of incarceration for individuals with mental illness. The National Alliance on Mental Illness reported that approximately 2 million individuals with serious mental illness in the U.S. are jailed each year, half of which receive no treatment. The growth in mental health courts has inspired research by the U.S. Department of Justice, Pew Charitable Trust, and other organizations on how to slow the rate of incarceration. Read More

Industry News

UPMC Acquires Four-Hospital System in North Central Pennsylvania. Pittsburgh-based UPMC health system has completed its acquisition of Susquehanna Health, a four-hospital system based in north central Pennsylvania. Susquehanna Health has been renamed UPMC Susquehanna to reflect its new partner. Read More

Altaris Capital Acquires Home Care Franchise Company Senior Helpers. *Home Health Care News* reported on October 25, 2016, that private equity firm Altaris Capital has acquired Maryland-based home care company Senior Helpers from Levine Leichtman Capital Partners for $125 million. Levine Leichtman Capital Partners acquired Senior Helpers in 2012. The company, founded in 2001, began franchising in 2005 and currently has 298 locations across the country. Read More

Court Square Capital Acquires Rehab Technology Provider National Seating & Mobility. Cain Brothers announced on October 26, 2016, that Court Square Capital Partners has acquired complex rehabilitation technology company National Seating & Mobility (NSM), which provides individuals with custom mobility, rehabilitation, and seating systems, from Wellspring Capital. NSM is based in Franklin, Tennessee. Cain Brothers served as a co-advisor on the transaction. Read More

Dialysis Provider Allegedly Steered Medicaid-Eligible Patients to Commercial Plans. The *St. Louis Post-Dispatch* reported on October 23, 2016, that dialysis provider DaVita HealthCare Partners allegedly encouraged some Medicaid-eligible clients to enroll in commercial health insurance plans, which pay significantly more than Medicaid or Medicare. DaVita has denied the allegations. The Centers for Medicare & Medicaid Services said in the letter that steering patient away from Medicare and Medicaid could result in disruptions in care, changes in drug benefits, loss of dental care, and changes in provider networks. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
October, 2016	Nevada	Contract Awards	420,000
October, 2016	Washington, DC	RFP Release	200,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts	RFP Release	860,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Contract Awards	177,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Contract Awards	177,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Sept. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	115,736	33.1%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	46,330	34.1%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,012	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,982	37.0%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	4,990	4.0%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	310	1.6%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	61,651	54.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,156	15.2%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	38,658	23.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,477	41.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**353,302**	**28.2%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA WELCOMES…

Roxane Townsend, M.D., Managing Principal – Chicago, Illinois

Roxane joined HMA on Monday, October 3, 2016, as the Managing Principal for the Accountable Care Institute working out of our Chicago, Illinois office. Roxane comes to us most recently from the University of Arkansas for Medical Sciences (UAMS), where she served as Vice Chancellor for Clinical Programs and Chief Executive Officer of UAMS Medical Center since February 2013. Roxane provided strategic oversight and supported the expansion of UAMS's clinical programs through the development of the Integrated Clinical Enterprise, which included 15 service lines and the core services that support clinical activity.

Roxane previously served as Assistant Vice President for Health Systems at Louisiana State University, where she worked with the system's 10 hospitals and their clinics in the development of operational strategies and system-wide policies and programs. Additionally, Roxane served as CEO of the Interim LSU Public Hospital in New Orleans, Earl K. Long Medical Center in Baton Rouge and CEO of LSU Health Care Services Division. Roxane was as an Associate Professor in the Department of Medicine and the Department of Health Policy and Management at UAMS and an Associate Professor of Clinical Medicine at LSU.

Prior to joining LSU, Roxane was appointed by Louisiana Governor Kathleen Blanco as Secretary for the Louisiana Department of Health and Hospitals (DHH). She also served as the Medicaid Medical Director and Deputy Secretary for the Louisiana Department of Health and Hospitals.

Roxane completed her medical degree and her Internal Medicine Residency at Louisiana State University School of Medicine. She received her Bachelor of Science in Nursing from Duquesne University. Roxane is ABIM Board Certified in Internal Medicine.

Carol Bruce-Fritz, Principal – Denver, Colorado

Carol Bruce-Fritz joined HMA on Friday, September 23, 2016, as a Principal working out of our Denver, Colorado office. Carol comes to us most recently from the Community Health Partnership in Colorado Springs, where she served as Chief Executive Officer since 2010. Over a period of six years, she transformed the volunteer-led coalition with an annual budget of $100,000 into a thriving, influential $18 million organization. Working within Colorado's Accountable Care Collaborative (ACC) program, Carol built infrastructure to establish Accountable Care Organization (ACO) services, including practice transformation, care coordination, behavioral/physical health care integration, and rapid cycle innovation. She implemented a successful pay-for-performance payment incentive program for primary and specialty care within the primary care medical home model and led the development of a regionally-based Health Information Exchange (HIE) project –the first bi-directional exchange of data between ambulatory and acute providers in Colorado.

Carol previously founded and worked as a consultant for BruceFritz and Associates, where she focused on nonprofit strategic planning, business planning, financial sustainability, branding, governance, change management and organizational development.

Additional positions that Carol has held include Executive Director of the Catamount Institute, Vice President of Corporate Communicates for Pikes Peak United Way, and Division Director of Communications for the American Cancer Society. She was a Homelessness Trustee for the City of Colorado Springs and serves on the board of the Continuum of Care for homelessness for the Pikes Peak region. She was instrumental in the founding of the Colorado Network of Health Alliances and served on its leadership council.

Carol received her Bachelor of Arts Degree in Communications and U.S. History from the University of Colorado.

David Rogers, Principal – Tallahassee, Florida

David Rogers joined HMA on Monday, September 30, 2016 as a Principal working out of our Tallahassee, Florida office. David comes to us most recently from the Florida Agency for Health Care Administration (AHCA), where he served as the Assistant Deputy Secretary for Medicaid Operations. He functioned as the Medicaid program's Chief Operations Officer from 2012 to 2016. David actually returned for a second tour within the state government in Florida. From 1996 to 2003, he held several highly responsible professional and managerial positions within the Agency, administering various aspects of Florida Medicaid, including Medicaid managed care, long-term care and behavioral health programs.

In 2003, David headed west to accept an executive level appointment as part of the Executive Leadership Team for the Idaho Department of Health and Welfare, the state's umbrella health and human services agency. As State Medicaid Director, he was responsible for administering all aspects of the state's Medicaid and Children's Health Insurance Programs.

Immediately preceding his return from the AHCA, David was a Senior Advisor with Public Consulting Group, a privately held consulting firm offering management advisory services primarily to government clients. In this role, he provided leadership on consulting engagements focused on various aspects of health care reform under the Affordable Care Act.

Additional roles David has held include Director of Business Development for MedAssurant (now Inovalon) and Vice President of Development and VP of Customer Support with APS Healthcare prior to the company's acquisition by Universal American.

David received his Bachelor of Arts degree and a certificate in Health Services Administration from Florida State University.