

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... *January 11, 2017*



In Focus



HMA Roundup



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THIS WEEK

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- **HMA WELCOMES: DAVID BERGMAN (NEW YORK); TOM DENBERG, M.D. (DENVER); ANN FILIAULT (ALBANY); BREN MANAUGH (SAN ANTONIO); BARBARA BUTLER-MOORE (TALLAHASSEE); TYLER DEINES (DENVER); CARA HENLEY (ALBANY); AMANDA TERNAN (SAN ANTONIO)**

IN FOCUS

HHS SELECTS EIGHT STATES TO PARTICIPATE IN CCBHC DEMONSTRATION

This week, our *In Focus* section comes to us from HMA Principals Meggan Schilkie, Joshua Rubin, and Heidi Arthur in our New York City office and the HMA national behavioral health team. On December 21, 2016, the U.S. Department of Health and Human Services (HHS) announced the selection of eight states for participation in a two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration program “designed to improve behavioral health services in their communities.” The eight states are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. The demonstration projects are slated to begin on July 1, 2017. They build on a total of 24 state planning grants issued by HHS in 2015 to support states in designing their certification process. Nineteen of the 24 states submitted applications to participate in the demonstration program, and the eight awardees were selected from this pool of 19 applicants.

CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. The Excellence in Mental Health Act demonstration program, or the “Excellence Act,” is a two-year initiative with the stated goal of expanding access to mental health and substance use services in community-based settings, including in rural areas, with a particular focus on veterans, services to Native American tribes, and other underserved populations.

Some estimates have placed the investment of funds associated with this project at more than \$1 billion, which would make it the largest investment in mental health and substance use services in recent history. Behavioral health stakeholders around the country have identified this as a parallel construct to Federally Qualified Health Centers (FQHCs), allowing behavioral health providers to access similar levels of reimbursement for community-based care to high-need underserved populations and communities.

The Excellence Act established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs) and established that these centers would receive an enhanced Medicaid prospective payment rate based on projected costs. States must certify that each CCBHC offers the following services either directly or through a formal contract with a designated collaborating organization (DCO) with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Must be Provided Directly by CCBHC
Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization
Screening, assessment, and diagnosis including risk management
Patient-centered treatment planning
Outpatient mental health and substance use services

May be Provided by CCBHC and/or DCO
Primary care screening and monitoring
Targeted case management
Psychiatric rehabilitation services
Peer support, counseling services, and family support services
Services for members of the armed services and veterans
Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)

All states were allowed to select one of two reimbursement models to evaluate as part of the demonstration project: PPS 1 or PPS 2. (a cost-based, per clinic rate that is paid through a fixed, *daily* rate for all CCBHC services provided to a Medicaid beneficiary or a cost-based, per clinic rate that is paid through a fixed, *monthly* rate for all CCBHC services provided to a Medicaid beneficiary. Under this option, the monthly rate varies according to clients' clinical conditions, and states had flexibility to decide how exactly PPS rates would vary based on their local needs. In addition, states who chose this option were *required* to make a QBP to CCBHCs who achieve the CMS- and state-specified measures. Only 2 of the 8 states selected a PPS 2 (NJ and OK) and only one (OR) of the 8 states did NOT opt to utilize quality bonus payments which were optional for PPS 1 and required for PPS 2.

Throughout the development and planning phases of the CCBHCs, many stakeholders and policymakers have raised questions about the possible tension between a Prospective Payment System (PPS) and the principles and goals of accountable care and value-based payments. Supporters of the CCBHC model conclude that the compatibility lies in the establishment of a continuum of mental health and substance use treatment services for individuals of all ages and an emphasis on needs assessment, population management, quality monitoring, and evaluation of outcomes, as well as an emphasis on open access, crisis intervention and diversion, care coordination, and follow-up post-discharge. Accessibility is promoted via peer, recovery, and clinical supports in the community and increased access through the use of telehealth/telemedicine, online treatment services, and mobile in-home supports (SAMHSA, Section 223 Demonstration Program for Certified Community Behavioral Health Clinics, 2016). All of these requirements enhance the ability of behavioral health providers to ultimately participate in pay-for-performance and value-based payment arrangements as critical partners in reducing the costs and improving health outcomes for individuals with serious behavioral health needs.

Even providers who are not certified under the official demonstration can seek to build out their continuum via partnerships and affiliations that mirror the CCBHC model, while also leveraging available housing resources and other social services linkages necessary to promote health, wellness, and sustained recovery. These networks can have substantial effects on the social determinants of health, which are proven to improve health outcomes and lower costs. Such networks will be well positioned to partner with accountable provider-led entities including accountable care organizations (ACOs), performing providers systems (PPSs), independent practice associations (IPAs) and integrated delivery systems led by hospitals, and FQHCs, in preparation for value-based arrangements.

The selected states' demonstration programs will be evaluated based on data from 21 quality measures collected through sources such as program records,

Medicaid claims, managed care encounter data, and clinic cost reports. Qualitative data also will be obtained from interviews with state officials and clinic staff. HHS will report on the access, quality, and financial performance of the demonstration programs annually beginning December 2017, using data from the evaluation.

For more information on the Section 223 Demonstration Program for CCBHCs visit: <http://www.samhsa.gov/section-223>

Potential Impact of Federal Healthcare Changes on CCBHCs

It does not currently appear as though the Trump administration will move to repeal or amend Section 223 of the Protecting Access to Medicare Act (P.L. 113-93), at least not in the near term. However, expansion beyond the initial eight states based on a successful demonstration project may be less likely. Other factors that would appear to provide some protection for the demonstration include:

- **Budget neutrality:** CCBHC demonstration state applications incented the establishment of budget neutral demonstrations. Budget neutrality means the demonstration cannot cost the federal government more than what would have otherwise been spent absent the demonstration. To demonstrate this, the state must provide its explanation of how the demonstration program will achieve savings sufficient to cover any additional cost of the program.
- **CBO scoring:** The Congressional Budget Office scored the Protecting Access to Medicare Act (PAMA) as having a net savings of \$1.2 billion between 2014 and 2024. However, the cost of the bill between 2014 and 2019 had an overall cost of \$17.7 billion, whereas from 2020-2024, the bill is scored with a savings of \$18.9 billion, so repealing it would mean that the upfront spending happened, but the back-end savings did not.
 - Section 223 (which established the CCBHC demonstration) is scored with a total cost of only \$1.1 billion, so it seems unlikely that it would rise to the level of attention required to single it out for repeal.
- The Protecting Access to Medicare Act was a politically essential piece of legislation, support for which was built over a significant time. Repeal of the whole bill would be problematic politically, and repeal of Section 223 alone would not generate a significant advantage.

HMA worked with many providers and states throughout the CCBHC development and planning process as well as with providers seeking to be certified as community behavioral health centers (CBHCs) and is pleased to see the demonstration projects proceeding around the country.



HMA MEDICAID ROUNDUP

Alabama

Alabama Medicaid Requests CMS Approval to Delay RCO Launch. *Modern Healthcare* reported on January 10, 2017, that Alabama is seeking approval from the Centers for Medicare & Medicaid Services (CMS) to further delay the implementation of Medicaid regional care organizations (RCOs), which were approved last year through an 1115 waiver. The state is now proposing that the waiver run from April 2017 through March 2022, with an expected RCO launch date of October 1, 2017. Approximately 650,000 of Alabama's roughly 1 million Medicaid members would be eligible for RCO enrollment. [Read More](#)

California

Governor's Budget Proposes Ending Coordinated Care Initiative. On January 10, 2017, California Governor Jerry Brown revealed that his proposed budget would discontinue the state's Coordinated Care Initiative (CCI). However, the Governor has proposed preserving elements of the CCI, including continuing the current dual eligible financial alignment demonstration, Cal MediConnect, as well as continuing to mandatorily enroll dual eligibles in Medicaid managed care and continuing the integration of long-term services and supports (LTSS) in managed care. The key changes under the proposed discontinuation of the CCI would impact the In-Home Supportive Services (IHSS) program. Governor Brown's proposed budget would remove IHSS benefit costs from health plan capitation rates. Additionally, the budget proposal would eliminate statewide authority for bargaining IHSS wages and benefits in the seven CCI counties; each county will regain bargaining authority. Finally, the budget proposal restores the state-county share of costs for IHSS, meaning counties will be responsible for 35 percent of the non-federal share of IHSS expenditures. Governor Brown's administration is prepared to work with counties to soften the impact of this restored county share of spending. The budget proposal estimates \$626.2 million in 2017-2018 general revenue fund savings as a result of these changes to CCI. [Read More](#)

Florida

HMA Roundup - Elaine Peters ([Email Elaine](#))

AHCA Requests Five-Year Extension on Statewide Medicaid Managed Care Waiver. *Florida Politics* reported on January 4, 2016, that Florida Governor Rick Scott's administration has submitted a request to the Centers for Medicare & Medicaid Services (CMS) for a five-year extension of the Managed Medical

Assistance (MMA) 1115 demonstration waiver. The current waiver runs from July 31, 2015, through June 30, 2017. If approved, the extension would run through June 30, 2022. Florida's MMA program provides primary and acute care through Medicaid managed care plans to most Florida Medicaid recipients. [Read More](#)

Governor Requests Enhanced Medicaid Match, Path to Permanence for 1115 Waivers. *Politico* reported on January 6, 2017, that Florida Governor Rick Scott has asked for increased Medicaid funding in a letter to U.S. House Majority Leader Kevin McCarthy. The letter requests 90 percent federal matching funds for "the most vulnerable populations." Florida currently receives a match of around 61 percent. The increased funding would be used to develop home and community-based services (HCBS) programs and provide more flexibility to the state's Medicaid managed care program. Governor Scott also stated in the letter that he believed Medicaid waivers should not have to be renegotiated so often, asking for a path to keeping Florida's current 1115 waiver in place permanently. [Read More](#)

AHCA Submits Behavioral Health Services Revenue Maximization Plan. As required by the 2016 Legislature in SB 12, the Agency for Health Care Administration (AHCA) and the Department of Children and Families were directed to develop a written plan by December 31, 2016, to evaluate alternative uses of increased Medicaid funding, to advance the goal of improved integration of behavioral health services and primary care services for individuals eligible for Medicaid through the development and effective implementation of the behavioral health system of care. [Read More](#)

Nursing Homes Seek to Exclude Some Seniors from Medicaid Managed Care. *Health News Florida* reported on January 11, 2017, that the Florida Health Care Association (FHCA), representing the state's nursing home industry, submitted a proposal asking the Florida Agency for Health Care Administration (AHCA) to exclude certain Medicaid beneficiaries over the age of 65 from managed care. AHCA interim director Beth Kidder stated that the agency objects to the proposal, which is aimed at seniors who need intensive long-term care. FHCA said it continues to support Medicaid managed care for individuals receiving long-term services and supports in community settings. [Read More](#)

Georgia

HMA Roundup - Kathy Ryland ([Email Kathy](#))

State Legislature to Consider Extension of Hospital Assessment. *STAT News* reported on January 6, 2017, that the Georgia state legislature will decide whether to continue the state's hospital provider assessment program during the session that starts January 9, 2017. The program, under which hospital assessments amount to roughly \$280 million annually, is currently set to expire later in 2017. The assessment funds equate to roughly \$600 million in federal matching funds for Medicaid, and advocacy groups say losing the money would be devastating for hospitals, especially in rural counties. [Read More](#)

Illinois

Appeals Court Rules HFS Did Not Overstep Authority in Reducing Medicaid Nursing Home Rates. *The Cook County Record* reported on January 4, 2016, that the Illinois Department of Healthcare and Family Services (HFS) did not overstep its authority in reducing Medicaid nursing home rates and that further legal action cannot be pursued in the Cook County Circuit Court, according to a ruling by the Illinois First District Appellate Court. Instead, the suit may be pursued in the Illinois Court of Claims. After HFS reduced reimbursements by approximately 2.25 percent in fiscal 2015, more than 150 nursing homes filed a lawsuit alleging that the method of rate calculation led to greater reimbursement cuts than were called for. The suit was dismissed, leading nursing homes to appeal. [Read More](#)

Kansas

Governor's Proposed Budget Raises Medicaid MCO, Hospital Assessment Rates. *The Topeka Capital-Journal* reported on January 11, 2017, that Kansas Governor Sam Brownback's fiscal 2018 budget proposal includes raising Medicaid managed care organization (MCO) and provider assessment rates. Under the proposal, MCOs would see assessment rates increase from 3.3 percent to 5.7 percent, while the hospital assessment rates would increase from 1.8 percent to 4.6 percent. The changes would be implemented in 2018, with revenues and subsequent increases in federal match to be used to increase reimbursement rates to rural hospitals. [Read More](#)

New Jersey

HMA Roundup - Karen Brodsky ([Email Karen](#))

Medicaid agency seeks public comment on revised 1115 waiver application renewal. On January 9, 2017, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) released the latest draft of the application to renew the Section 1115 "Comprehensive Waiver" which clarifies it by:

- Removing Medicare as a condition of Medicaid eligibility, removing the Integrating Care Options for Dual Eligible Individuals concept, including both the seamless enrollment and integrated enrollment option; and
- Adding additional details around the Medicaid Permanent Supportive Housing;
- Adding specifics around the types of models Medicaid is considering under the increased access/telehealth option; and
- Adding details around the population health initiative and the renewal hypothesis.

A summary of the initial public comment process is also available as Attachment E to the renewal application. DMAHS will present on the renewal during the Medical Assistance Advisory Committee (MAAC) meeting on January 23, 2017, from 10 am to 1 pm at the State Police Headquarters Complex and PHEAL Building in Ewing, New Jersey. [Read more](#)

Health Republic Co-op Insurer is Liquidated. *NJBIZ.com* reported on January 11, 2017, that Health Republic of New Jersey, a co-op insurer formed to offer marketplace coverage under the Affordable Care Act was put in liquidation. The insurer filed documents with the Department of Banking and Insurance to terminate the rehabilitation process that began in late 2016 and to begin liquidation. [Read More](#)

Three Health Care Organizations Form New Jersey Healthcare Executive Leadership Academy. *NJBIZ.com* reported on December 28, 2016, that three health care organizations have joined to form the New Jersey Healthcare Executive Leadership Academy. The Medical Society of New Jersey, New Jersey Hospital Association, and New Jersey Association of Health Plans will partner with Seton Hall University to form and launch the Academy. The Academy will begin with a \$150,000 grant from the Fannie Rippel Foundation. [Read More](#)

Marketplace Enrollment Increases 14 Percent Since Last Year. *NorthJersey.com* reported on December 21, 2016, that nearly 205,000 New Jersey residents have selected a Marketplace plan for health insurance to date. This represents an increase of 14 percent from December 2015. Residents have until January 31, 2017, to enroll. [Read More](#)

New York

HMA Roundup - Denise Soffel ([Email Denise](#))

Affordable Care Act Repeal and Impact on New York Medicaid. New York's Medicaid director, Jason Helgeson, stated that a repeal of the Affordable Care Act would undo two decades of state efforts to expand health coverage. Prior to the Affordable Care Act, New York had expanded Medicaid eligibility through its Family Health Plus program, covering parents up to 150 percent of the federal poverty level and childless adults up to 100 percent FPL. The waiver provisions that allowed the state to create that program have since been eliminated, and New York would need federal approval to restore them. As reported in *Crain's HealthPulse*, Helgeson said that if Republicans are successful in their repeal efforts, eligibility levels for Medicaid in New York would drop to 94 percent of the federal poverty level for parents with dependent children, down from the current level of 138 percent under the ACA, and all childless adults would lose coverage. Based on current enrollment levels, the state estimates that the repeal of the Affordable Care Act would result in over 2.7 million New Yorkers losing health coverage. [Read More](#)

Delivery System Reform Incentive Payment Program Spending. The mid-point assessment of New York's Delivery System Reform Incentive Payment (DSRIP) program indicates that more than half the federal money awarded to the 25 Participating Provider Systems (PPSs) that make up the remains unspent. The independent evaluation was meant to examine whether the state is on track to meet its goal of reducing avoidable hospitalizations by 25 percent over a five-year period. As reported in *Politico*, the PPSs had spent 43 percent of the money they received from the federal government, with more than 70 percent of the money going to either PPS administrative functions or to a hospital (it is worth noting that all but two PPSs are run by hospital systems). The evaluation also notes that most PPSs are behind on their Partner Engagement goals and need to focus attention and funding to engage key partners. Community-based

organizations, which are seen as critical partners in addressing social determinants of health, continue to lag in DSRIP funds flow. [Read More](#)

NY State of Health Open Enrollment Report. NY State of Health, the state's official health plan Marketplace, announced that more than 3.4 million people have enrolled in health insurance through December 24, 2016. With almost a month to go until the end of the 2017 Open Enrollment period, participation in the NY State of Health Marketplace has already increased more than 22 percent since the last Open Enrollment period ended on January 31, 2016. The breakdown of enrollment as of December 24, 2016, is as follows:

- Total cumulative enrollment: 3,472,214
- Total Medicaid enrollment: 2,332,683
- Total Non-Medicaid enrollment: 1,139,531
- Essential Plan (Basic Health Program): 635,909
- Qualified Health Plan: 217,995
- Child Health Plus: 285,627

[Read More](#)

North Carolina

Medicaid Expansion Proposal May Receive Expedited Federal Review. *The News&Observer* reported on January 9, 2017, that North Carolina's Medicaid expansion proposal may receive expedited review by federal regulators, according to Sylvia Burwell, Secretary of the U.S. Department of Health & Human Services. If the proposal is approved, North Carolina would be the 32nd state to expand Medicaid. Burwell's statement comes after two U.S. Representatives from the state sent a letter to HHS urging acting CMS Administrator Andy Slavitt to reject the expansion proposal. They argued that it is illegal for North Carolina Governor Roy Cooper, who took office in January 2017, to submit an expansion plan without the state Legislature's support. [Read More](#)

Ohio

HMA Roundup - Jim Downie ([Email Jim](#))

Ohio Medicaid Expansion Assessment cites Benefits. *The Columbus Dispatch* reports a recently completed comprehensive assessment of the Ohio Medicaid Expansion shows increases in the health and financial well-being of those made eligible. The assessment, mandated by the Ohio legislature, reported that it was easier for the people to keep or find work, and most reported better health and financial security as a result of obtaining coverage. Among the many findings, the telephone survey found: most enrollees were uninsured prior to obtaining coverage, access to services improved, emergency room use declined, previously unknown or unaddressed chronic health conditions were detected, and the percentage of enrollees with medical debt fell by nearly half. [Read More](#)

Governor Kasich Signs Bill to Combat Opiate Addiction. *The Toledo Blade* reports that Governor Kasich has signed legislation that targets Ohio's opiate epidemic. Senate Bill 319 addresses a numbers of issues including: expanding

access to the anti-overdose drug naloxone, closing an exemption in current law that allows sole proprietors in private practice to directly distribute medications to patients without oversight from the Ohio Board of Pharmacy, requiring pharmacy technicians to register with the state Pharmacy Board, and allowing for the expansion of for-profit medication assisted treatment clinics. [Read More](#)

Autism Services Coverage Mandated in New Law. *10TV-Columbus* reports that under newly enacted House Bill 463, insurance companies will be required to cover autism treatments, including Applied Behavior Analysis. [Read More](#)

Ohio Updates Licensure of Advanced Practice Nurses. The *Lake County News-Herald* reports that among 28 bills signed by Governor Kasich was House Bill 216. HB 216 updates Advanced Practice Registered Nursing licensure laws. Some of the changes made by the law include: grants an APRN other than a certified registered nurse anesthetist authority to prescribe and furnish most drugs as part of the APRN license without need for a separate certificate to prescribe or completion of a supervised externship; requires that the Board establish an exclusionary drug formulary specifying the drugs an APRN is not authorized to prescribe; increases to five (from three) the number of APRNs with whom a physician or podiatrist may collaborate at the same time in the prescribing component of an APRN's practice. [Read More](#)

Oklahoma

Health Care Authority Requests \$200 Million in Additional Funding. *The Oklahoman/AP* reported on January 10, 2016, that the Oklahoma Health Care Authority is seeking a \$200 million increase in Medicaid funding for fiscal 2018. Of this, \$120 million would go to maintaining existing programs, while \$24 million would go to restoring a 3 percent rate cut to providers that was implemented last year. The agency received nearly \$1 billion in state funding last year. [Read More](#)

Pennsylvania

HMA Roundup - Julie George ([Email Julie](#))

DHS Announces Preliminary HealthChoices Awards. Pennsylvania Department of Human Services (DHS) Secretary Ted Dallas announced on January 5, 2017, that the agency will negotiate contracts to deliver physical health services through the Pennsylvania HealthChoices program with the following managed care organizations by region:

- **Southeast Region:** Gateway Health, Health Partners Plans, PA Health and Wellness (Centene), UPMC for You, Vista-Keystone First Health Plan
- **Southwest Region:** Gateway Health, PA Health and Wellness (Centene), UPMC for You, Vista-AmeriHealth Caritas Health Plan
- **Lehigh/Capital Region:** Gateway Health, Geisinger Health Plan, Health Partners Plans, PA Health and Wellness (Centene)
- **Northeast Region:** Gateway Health, Geisinger Health Plan, UPMC for You

- Northwest Region: Gateway Health, UPMC for You, Vista-AmeriHealth Caritas Health Plan

The three-year, \$12 billion contracts include a 30 percent target for payments based on outcomes rather than quantity. The RFP was re-issued in July 2016 following a court order initiated by Aetna. Aetna, UnitedHealthcare, and AmeriHealth Caritas have filed protests, state officials said. The new contracts are scheduled to start in June, but Dallas said it could take months to work through the bid protests. Pending regulatory approval and successful completion of readiness review, the three-year agreement is expected to commence June 1, 2017. [Read More](#)

Two Insurers File Protest of HealthChoices Contract Awards. *The Pittsburgh Post-Gazette* reported on January 6, 2017, that Pennsylvania rejected bids by Aetna and UnitedHealthcare to coordinate medical care for their Medicaid members, and both insurers are protesting the awards. "We strongly disagree with the state's decision, have filed a formal protest with the Pennsylvania Department of Health Services and are aggressively pursuing all options and remedies at our disposal," UnitedHealthcare said in a statement. United has a combined total of more than one million members in all of its plans in Pennsylvania, including commercial and military plans. In a statement, Aetna said it was disappointed by the announcement and had also filed a protest with the state. The company has more than 210,000 Medicaid members in Pennsylvania. [Read More](#)

North Philadelphia Health System Files for Bankruptcy. North Philadelphia Health System filed for Chapter 11 bankruptcy on December 30, 2016, after years of financial troubles. In December 2015, the system closed St. Joseph's Hospital. The hospital shut down in March 2016, affecting 675 workers. NPHS continued to struggle financially after closing St. Joseph's, leading the system to file for bankruptcy. In its bankruptcy petition, NPHS listed its liabilities at between \$10 million and \$50 million and the total value of its assets in the same range. The system said in its filing that it has at least 1,000 creditors. NPHS currently operates two facilities in Philadelphia. In a motion filed Monday, NPHS asked the bankruptcy court to enter an order restraining utility companies from discontinuing services, as it requires uninterrupted utility service to treat patients. The system also asked the court for authorization to maintain employees' current wages and benefits. A hearing on that motion is scheduled for Thursday. [Read More](#)

Texas

HMA Roundup Dianne Longley ([Email Dianne](#))

Texas Announces Plans to Request 1115 Waiver Extension. The Texas Health and Human Services Commission (HHSC) announced its intentions to submit a request to the incoming CMS administration for an extended continuation of the current Medicaid 1114 waiver. The initial waiver has been in place since 2011 and was scheduled to end in September 2016. In May, HHSC received a fifteen month extension, maintaining the current program funding and operations through December 2017. However, the state and CMS have been involved in ongoing negotiations since the extension was announced, and CMS has indicated funding would likely be reduced under an extended renewal of the waiver. In the new request, Texas intends to request a continuation through

September 30, 2019, at current funding levels for the Uncompensated Care pool and Delivery System Reform Incentive Payment Program pool. The State also would continue the waiver managed care provisions under the extension. Though the letter has not yet been submitted, the State reports it will submit the request soon after the new administration assumes operations of CMS.

Texas Announces New Schedule for Future Managed Care Procurements, Releases Draft Proposal for CHIP Rural Service Areas Procurement. At the Biannual Managed Care Stakeholder Meeting on January 5, 2017, the Texas Health and Human Services Commission (HHSC) released planned operational start dates for re-procurement of Medicaid and CHIP managed care services contracts. HHSC announced the re-procurement process will begin approximately 18 months prior to the planned operational start dates, beginning with the release of draft Requests for Proposals (RFP) or Requests for Information (RFI). In December, HHSC released its draft RFI for the proposed STAR+PLUS statewide procurement. HHSC identified operational start dates for the Medicaid and CHIP Dental statewide program re-bid as March 2019, with procurement activities beginning around September 2017. The STAR and CHIP statewide managed care re-procurement activities will begin around September 2018, with start dates beginning March 2020.

On January 5, 2017, HHSC also released the draft CHIP Rural and Hidalgo Service Areas RFP, with comments due by January 23, 2017. According to the draft proposal schedule, HHSC intends to publish the final RFP on February 21, 2017, with proposals due April 10, 2017 ([Link to DRAFT RFP](#)). Award announcements are scheduled for September 1, 2017, and the program start date is September 1, 2018.

Texas currently has a total of thirteen CHIP Service Areas, but this procurement is limited to the four CHIP Rural and Hidalgo Service Area contracts which have been in effect since September 1, 2010. The contracts had an initial contract period of three years with options to extend for additional periods through August 31, 2018. HHSC is issuing the RFP to ensure sufficient time to complete the lengthy procurement and contracting process prior to the August 2018 deadline, while also meeting legislative requirements to align the CHIP Service Areas with Medicaid managed care Service Areas. Current CHIP Rural and Hidalgo Managed Care Organizations (MCOs) include Molina Healthcare (with 37,047 CHIP members statewide) and Superior Health Plan (Centene, with a total of 85,179 CHIP enrollees statewide).

The initial contract will continue through February 29, 2020, with the option to extend the contract for an additional period not to exceed eight operational years. HHSC intends to contract with a minimum of least two MCOs for each Service Area (West Texas, Central Texas, Northeast Texas and Hidalgo) but notes the number could be higher.

CHIP serves more than 530,000 children statewide, including children under age 19 living in a family with incomes at or below 201 percent of the federal poverty level who do not qualify for Medicaid. With some exceptions, children must generally be uninsured for at least 90 days prior to coverage. In addition, CHIP perinatal coverage insures pregnant women who are ineligible for Medicaid due to income or immigration status. Upon delivery, newborns will continue to receive CHIP benefits for 12 months or will be moved to Medicaid if eligible.

Texas Legislative Session Begins. The biennial Texas Legislature, which reconvened January 10, 2017, faces a 2.7 percent decrease in revenue available

for the 2018-2019 budget appropriations, due primarily to decreasing oil and gas prices. Texas Comptroller Glenn Hegar released his biennial revenue estimates on January 9, reporting the Legislature will have \$108.0 billion in Texas General Revenue available for distribution. Hegar's report estimates an additional \$74.9 billion in federal receipts will supplement state funding for programs, including Medicaid, CHIP, and other health and human services initiatives. In addition, legislators have \$10.2 billion available in the state's Rainy Day Fund, which Texas legislators are generally reluctant to spend. Last year, amid lower budget projections, the governor directed state agencies to submit budget requests that are 4 percent lower than the 2016-2017 agency appropriations. Certain programs were exempted from the reduction, including Medicaid and CHIP client services and behavioral health programs.

Total appropriated funds for Medicaid services in 2016-2017 was \$56.15 billion. Texas Health and Human Services Commission (HHSC) has requested Medicaid appropriations of \$61.09 billion for 2018-2019, plus additional exceptional items totaling \$4.8 billion. Requested CHIP funds total \$2.01 billion compared to \$1.8 billion in 2016-2017. Additional funds of \$1.3 billion are requested for Medicaid and CHIP Contracts and Administration services, down from \$1.6 billion in 2016-2017. Baseline funding requests include caseload growth for both Medicaid and CHIP. Medicaid growth is projected at 0.4 percent in FY 2018 and 1.9 percent in 2019; CHIP growth is projected at 3.3 percent and 4 percent for 2018 and 2019, respectively. Total Medicaid caseload is projected at 4,214,516 in 2019 compared to 4,082,965 in 2017. CHIP caseload is expected to increase from 376,366 in 2015 to 445,312 in 2019. Additional budget information is available [here](#).

Following the induction of newly elected legislators Tuesday morning, the legislature will start slowly as it waits for new Senate committee appointments from Lieutenant Governor Dan Patrick and House of Representative appointments from Speaker Joe Straus. No hearings will be scheduled until committee appointments are completed.

House Committee Report Makes Behavioral Health Access Recommendations. *The Texas Tribune* reported on January 5, 2017, that the Texas House Select Committee outlined recommendations for the state to address mental health and behavioral health access issues in a report published January 5, 2017, just days before the beginning of the upcoming state legislative session. The committee concludes that community collaboration is increasingly necessary to tackle access issues. The report's recommendations include increasing the state's budget for investigations of behavioral health plans, implementing a state mental health parity law, building new state hospitals to increase bed counts, increasing access to substance use disorder services, and investing in jail diversion programs. The state has appropriated \$6.7 billion in 2017 for mental health and behavioral health services, half of which goes to the Medicaid program. [Read More](#)

Virginia

Virginia Could Lose \$314 Million if ACA Repealed, Says Medicaid Director. *Richmond Times-Dispatch* reported on January 9, 2017, that a repeal of the Affordable Care Act (ACA) could have a \$314 million annual budget impact in the state of Virginia, according to Cynthia B. Jones, director of the state Department of Medical Assistance Services. Jones said the state could lose more

than \$123 million in the next fiscal year and more than \$190 million the following fiscal year if the ACA was repealed, largely from the loss of pharmacy rebates under the managed care program and the loss of federal matching funds for CHIP. [Read More](#)

Washington

HCA Receives CMS Approval for 1115 Waiver Proposal. The Washington State Health Care Authority announced on January 9, 2017, that CMS has approved the five-year Washington State Medicaid Transformation Project 1115 waiver. The waiver provides up to \$1.1 billion in incentives for high-quality care through a Delivery System Reform Incentive Payments (DSRIP) program, supported by regionally-focused Accountable Communities of Health. [Read More](#)

West Virginia

Governor-elect Names Bill Crouch as DHHR Secretary. *West Virginia MetroNews* reported on January 6, 2017, that West Virginia Governor-elect Jim Justice has named Bill Crouch as the new Department of Health and Human Resources (DHHR) secretary. Crouch will replace Karen Bowling. DHHR administers the state's Medicaid program. Crouch founded a health care consulting firm in the 1980s and previously served as the executive director of the West Virginia Health Care Cost Review Authority. [Read More](#)

National

Exchange Enrollment Continues to Grow, Topping 11.5 Million in December. *Modern Healthcare* reported on January 10, 2017, that state and federal Exchange enrollment grew to 11.5 million as of December 24, 2016, up 300,000 from a year earlier. Including individuals not eligible for Medicaid who purchased Basic Health Plans, a total of 12.2 million customers signed up this enrollment period. The rate of returning customers increased from 60 percent to 65 percent this enrollment period. [Read More](#)

CMS Extends Moratorium on New Home Health Agencies in Four States. *Home Health Care News* reported on January 9, 2017, that the Centers for Medicare & Medicaid Services (CMS) has extended a moratorium on new home health agencies (HHAs) in Florida, Illinois, Michigan, and Texas by six months, effective January 29, 2017. Targeting states with relatively high instances of home health fraud, waste, and abuse, the ban prevents new HHAs from being certified for Medicaid and the Children's Health Insurance Program in the selected states. [Read More](#)

Trump Calls for Quick Passage of ACA Replacement Following Repeal. *The Hill* reported on January 10, 2017, that President-elect Donald Trump stated that an Affordable Care Act (ACA) replacement bill should come shortly after the repeal bill. He said that multiple weeks would be considered a long time between the passage of repeal legislation and of replacement legislation. President-elect Trump also encouraged Democrats to work with Republicans to create replacement legislation. [Read More](#)



INDUSTRY NEWS

Centene, Physician Groups to Partner on North Carolina Medicaid Plan.

Centene announced on January 10, 2017, that it will partner with the North Carolina Medical Society (NCMS) and the North Carolina Community Health Center Association to form a provider-led Medicaid health plan in the state. The joint venture, called Carolina Complete Health, hopes to compete in the state's upcoming Medicaid managed care program. Centene would manage the financial and daily operations, while the Carolina Complete Health Network would provide medical management services. The Network would be owned by NCMS, physicians, Physician Assistants, Nurse Practitioners and Federally Qualified Health Centers. [Read More](#)

Tenet to Sell Home Health and Hospice Business, Several More Hospitals.

Modern Healthcare reported on January 9, 2017, that Tenet Healthcare Corp. announced it is looking to divest its home health and hospice lines of business as part of a strategy to focus on ambulatory care and on markets where the company has high market share. Tenet also announced it has letters of intent to sell several more hospitals. The company previously announced it will exit the health plan business. Last year, Tenet sold five hospitals in Atlanta, Georgia to WellStar Health System for \$661 million. [Read More](#)

Optum to Acquire Surgical Care Affiliates for \$2.3 Billion.

Modern Healthcare reported on January 9, 2017, that UnitedHealth's Optum subsidiary will acquire Illinois-based Surgical Care Affiliates (SCA) for \$2.3 billion in cash and stock. SCA serves 1 million patients annually in its 190 ambulatory surgery centers and surgical hospitals. In 2015, SCA had operating revenues of \$1.1 billion. The deal is expected to close in the first half of 2017. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 18, 2017	Washington, DC	Proposals Due	190,000
January 23, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
February 16, 2017	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
March 15, 2017	Massachusetts	Proposals Due	850,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
June 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
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 (Nov. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	112,468	32.1%	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	46,216	34.0%	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	13,857	14.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,656	36.7%	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	4,860	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	384	1.9%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	70,315	61.7%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	4,086	16.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	9,611	17.9%	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	36,736	21.9%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	29,186	44.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	10 States			1,254,200	364,375	29.1%	

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

HMA WELCOMES...

David Bergman, Principal - New York, New York

David comes to HMA most recently from Healthcare Intelligence Partners, a health IT strategy consulting practice he founded in 2009. As a Principal, David built and operated a HIPAA-complaint medical claims analytic capability for Marketplace Solutions and Incentives Project (MSIP). David was the lead consultant to the Arizona Health eCollaborative (AzHeC) where he supported strategies for integrating behavioral and physical health data in a single Health Information Exchange. He also supported a 2½ -year project with the Texas Council of Community Centers to advance the sector's understanding of and capacity to leverage health information technology. David served as the Executive Director and Founder of the Association of Regional Centers for Health IT (ARCHIT), a trade association representing federally funded Regional Extension Centers for Health IT.

Prior to and concurrent with his work at HCIPartners, David worked at Valera Health where he served as the Director of Operations. While at Valera, David built infrastructure and operational capacity for this digital behavioral health startup, developed and implemented HIPAA compliance policies and procedures, and negotiated key contracts for organizational partnerships.

From 2010 to 2011, David served as a Project Officer with the Office of the National Coordinator for Health Information Technology where he fostered the creation and strategic development of seven Regional Extension Centers (RECs) in Texas, Mississippi, Arkansas, and Louisiana with combined federal support of more than \$55 million. David advised grantees on tactical and strategic goals by cultivating partnerships with key state and federal agencies, private payers, associations and provider groups around adoption and meaningful use of electronic health records. Additional positions David held include Associate Director of Behavioral Health at Kings County Hospital Center in Brooklyn, Senior Manager of Program Management with Health Dialog, Founder of TCO Health, Inc., Senior Policy Analyst at the National Academy for State Health Policy, and Senior Policy Associate at the Coalition for Behavioral Health.

David received his Master of Public Administration degree from New York University and his Bachelor of Arts degree from the University of Chicago. He is a board member of the Texas eHealth Alliance and Secretary of the Casey Health Institute, an integrative health center in Gaithersburg, MD.

Tom Denberg, M.D., Principal - Denver, Colorado

Tom comes to HMA most recently from the Carilion Clinic, a multi-hospital system in Virginia, where he served as Executive Vice President and Chief Strategy Officer. In this role, Tom led the development of a population health management platform and new payment care model while overseeing the organization's Medicare Advantage and Managed Medicaid Health Plans. The work focused on transitioning the system from a fee-for-service model of care to one focused on greater value, patient engagement, financial risk-sharing and physician leadership.

Prior to joining Carilion, Tom directed the development of a quality and patient safety department at Atrius Health, a large multispecialty group in Boston. He established a new, combined Atrius Health/Harvard Vanguard Department of

Quality and Patient Safety and was responsible for supporting improvements in quality, cost, and patient safety outcomes for 1,000 providers.

Tom previously served as a Professor of Medicine at the University of Colorado Health System where, in addition to mentoring trainees and junior faculty and carrying out health systems research, he directed hospital and ambulatory quality improvement initiatives, developed innovative and successful population health management programs, and devised key components of an employee wellness and prevention offering.

Tom received his M.D. and Ph.D. in Medical Anthropology from the University of Illinois, Urbana-Champaign. He received his Bachelor of Arts degree in Philosophy and Biology from Reed College in Portland, Oregon. He is the immediate past Chair of the American College of Physicians Clinical Guideline Committee, a body that produces evidence-based clinical practice guidelines and promotes clinical appropriateness in patient care.

Ann Filiault, Principal – Albany, New York

Ann comes to HMA from PricewaterhouseCoopers, where she served as a Director in New York City and Albany. In this role, Ann was responsible for leading large teams of consultants and specialists and crafting final reports and deliverables for clients. She specializes in strategic and financial planning, transaction support, turnaround analysis and implementation, and regulatory compliance and operational improvement for hospitals, academic medical centers and health systems. In her 28 years with PricewaterhouseCoopers, Ann delivered large, multi-workstream engagements and acted as account director for relationships at several health systems. She assisted acute care providers and facilitated boards, executive leadership and medical staff leadership in making decisions regarding strategic direction and operational configuration.

Some of her most significant accomplishments with PricewaterhouseCoopers include facilitating the reconfiguration of clinical service lines across campuses post-merger for an academic medical center; leading the board of a large visiting nurse association in the definition and assessments of strategic options around partnering; developing compliance analysis to identify and assist hospitals with short-stay concerns around the implementation of the two-midnight rule and OIG initiatives; providing financial and operational analysis to support business planning, physician growth strategies, and Certificate of Need processes; and analyzing Medicare and Medicaid third-party reimbursement opportunities. She led the product development of an analytic tool fed by medical records information, including initial product conceptualization, content design and development, user experience design, implementation within daily work flow, and training and ongoing support of users.

Ann has served as a Board Member with the Helena Ptochia Foundation since 2010 and supports the Spoon Foundation, which provides nutritional supplements and staff education to institutionalized children primarily in Kazakhstan.

Ann received her Master of Business Administration from Union College and her Bachelor of Arts degree in French from Dartmouth College.

Bren Manaugh, Principal – San Antonio, Texas

Bren comes to HMA from the Center for Health Care Services, a community mental health center in San Antonio serving over 25,000 individuals annually,

where she most recently served as Vice President of Adult Services. Bren provided executive leadership and managed the service division with an annual operating budget of \$33 million and 310 employees. She was the executive driver of nationally-recognized innovative integrated care models that improved the bottom line and customer outcomes. Bren implemented business and clinical strategies to capitalize on the rapidly changing healthcare environment, adhering to performance standards and continuous improvement processes to achieve high-quality clinical outcomes while increasing revenue and effectively managing compliance and risk.

Prior to her role as Vice President, Bren served as the Director of Business Development, Compliance and Quality Assurance. In this role, Bren analyzed and integrated strategic goals, organizational resources and core competencies to identify, develop and respond to funding opportunities through procurement and grant processes. She ensured compliance of business development with regulatory and contract requirements, clinical standards of care, and alignment with research and stakeholder partnerships. Bren also served as Corporate Compliance Officer, Client Rights Protection Officer, and Primary Manager of Risk Management Policies and Activities. She is a Certified Professional in Healthcare Quality (CPHQ) and has experience with Lean Management.

Her accomplishments include design, successful implementation, and strategic sustainability planning for Texas Medicaid 1115 Waiver DSRIP projects and design and successful implementation of innovative clinical programs integrating primary care in behavioral health settings with demonstrated cost and quality impact and technology solutions for an integrated patient health record. The latter project included the development of a successful model for high-utilizers of emergency departments and others with complex care needs with technology solutions for providing real-time patient information in the HIE to divert from unnecessary inpatient hospitalizations. Additionally, Bren provided executive administration of clinical programs in the nationally-recognized Bexar County jail diversion system and has developed and implemented numerous local, state, federal and private grants, including most recently Robert Wood Johnson D.A.S.H. grant and SAMHSA PBHCI grants. As an executive leader, she led the agency's strategic work to translate effective clinical outcomes into value based purchasing agreements.

Bren received her Master of Social Work from the University of Kansas and her Bachelor of Science degree in Biology from the University of Minnesota. She is a Licensed Clinical Social Worker and Certified Supervisor for Licensed Clinical Social Workers. She is adjunct faculty at the University of Texas-San Antonio Master of Social Work Program.

Barbara Butler-Moore, Senior Consultant - Tallahassee, Florida

Barbara comes to HMA most recently from the Florida Agency for Health Care Administration (AHCA) where she served as an Administrator. In this role, she managed the Utilization Management Contracts Section within the Quality Bureau, which is responsible for programmatic design and implementation of utilization management and care coordination contracts, the Electronic Visit Verification program, the Healthy Start program, the Hemophilia services contract, and the Payment Error Rate Measurement project. She was also responsible for the development of competitive and non-competitive procurements, contract management and monitoring. Prior to her role as an Administrator, Barbara served as a Senior Management Analyst for the

Performance, Evaluation and Research Unit, where she managed a team of contract managers responsible for the Medicaid waiver evaluation contracts, the KidCare evaluation contract, program specific research contracts and the Medicaid Health Plan Report Card. Additional roles within AHCA include Government Analyst, Program Administrator, Medical Health Care Program Analyst, Statewide Inpatient Psychiatric Program Contract Manager, and Infant Mental Health Policy Lead.

Prior to AHCA, Barbara served as a Clinical Director at the Community Intervention and Research Center (CIRC), a child-focused community mental health agency in Tallahassee. In this role, Barbara provided clinical oversight and was responsible for utilization management activities, establishing and implementing policies and procedures, quality improvement processes, training staff, clinical supervision of bachelor and master's level clinicians, and the oversight of services provided within the agency.

Previous roles include Mental Health Counselor for Wyandot Center for Community Behavioral Health in Kansas City, Mental Health Counselor for Catholic Community Services of Lawrence, Foster Care Supervisor and Therapeutic Case Manager at Kaw Valley Center, Medical Social Worker at Lawrence Memorial Hospital, and Counselor for DCCCA in Lawrence, Kansas. Barbara has volunteered with the Guardian Ad Litem Program in Florida since 2012.

Barbara received her Master of Social Work degree from the University of Nebraska and her Bachelor of Arts degree in Psychology from the State University of New York College at Buffalo. She is a Licensed Clinical Social Worker and Certified Contract Manager in the State of Florida.

Tyler Deines, Senior Consultant - Denver, Colorado

Tyler comes to HMA most recently from the Colorado Department of Health Care Policy and Financing (HCPF) where he served as a Program Development and Evaluation Manager for the Division for Intellectual and Developmental Disabilities. In this role, Tyler served as the project lead in the redesign of the Medicaid Home and Community-Based Services waivers serving adults with intellectual and developmental disabilities. Tyler was responsible for policy and program development to include person-centered planning and service delivery, participant direction of services, waiver modernization and other initiatives of the Governor's Community Living Advisory Group. Tyler implemented a stakeholder-driven initiative to amend the state's definition of developmental disability in order to include those with significant impairments in adaptive behavior. He also led an initiative for the development of a comprehensive data strategy to provide program and contract managers with user-friendly and actionable expenditure, utilization and program quality metrics.

Tyler previously served as the HCBS Administrator in the Long-Term Supports & Services Division of HCPF. Tyler was the subject matter expert and lead administrator for HCBS waivers and was responsible for the general operation of the waiver programs, maintaining cost effectiveness, and ensuring compliance with the quality and reporting requirements established by CMS. In this role, Tyler convened an internal workgroup to modernize waiver service expenditure and utilization report capabilities and coordinated with data analysis staff to create a web portal that provided accurate and timely data to program managers and generated the annual CMS 372 cost reports.

Prior to the Colorado Department of Health Care Policy and Financing, Tyler served as a Center Manager at Heart 2 Heart Home Respiratory Care where he managed operations, service quality, inventory and profitability of a home respiratory and durable medical equipment supplier. Tyler also served as a Day Services Technician with Hilltop Community Resources, Inc.

Tyler received his Bachelor of Business Administration degree from Colorado Mesa University and is currently working toward his Master of Science degree with a concentration in Healthcare Policy and Regulatory Leadership from the University of Denver.

Cara Henley, Senior Consultant - Albany, New York

Cara comes to HMA most recently from the Healthcare Association of New York State (HANYS) where she served as Senior Director of Insurance, Managed Care and Behavioral Health. In this role, Cara oversaw and directed work activities, including project management, strategic planning, budgeting and successfully implementing the annual work plan. She analyzed the impact of state and federal legislative and regulatory activity on providers and health plans, including detailed knowledge of commercial insurance, Medicare Advantage, Medicaid Managed Care, the Delivery System Reform Incentive Payment (DSRIP) Program, the State Health Innovation Plan (SHIP), Exchanges and overall implementation of the Affordable Care Act. She continually researched and developed expertise on population health models, behavioral health/primary care integration, Accountable Care Organizations (ACOs) and value-based risk contracting.

In over 8 years with HANYS, Cara also held the following positions: Director of Insurance, Managed Care and Behavioral Health; Associate Director of Insurance and Managed Care; Manager of Insurance and Managed Care; and Policy Specialist in Managed Care. She presented and taught teams and large groups at various programs and events on a wide range of insurance and managed care related topics, including the behavioral health transition to managed care, behavioral health integration models under DSRIP, risk-based contracting and value-based payment, behavioral health reimbursement and billing guidance. Cara fostered relationships with key stakeholders including financial representatives at healthcare facilities throughout New York State and other representatives from governmental agencies, health plans and legislative staff.

Prior to HANYS, Cara served as a Legislative Assistance for New York State Senator Eric Adams. She provided support to the Senator and Legislative Director, researched various pieces of legislation and pertinent amendments, and responded to constituent concerns. As a Financial Analyst and Legal Assistant at Goldberg & Bokor, LLP, Cara assisted two attorneys and drafted legal briefs, Supreme Court Article 78 proceedings, and petitions for actions before administrative agencies including the New York City Water Board, New York State Public Service Commission, New York City Department of Environmental Protection and New York City Department of Finance.

Cara received her Bachelor of Arts degree in Political Science from the University at Albany, SUNY. She earned a Certificate in Healthcare Leadership and Advancement from Cornell University and is certified in Lean and Continuous Improvement.

Amanda Ternan, Senior Consultant – San Antonio, Texas

Amanda comes to HMA from the Center for Health Care Services where she most recently served as a Consultant for the Adult Behavioral Health Division. In this position, Amanda was the project manager of 3 Texas Medicaid 1115 DSRIP projects and coordinated all project deliverables including monthly status reports, bi-yearly deliverables, metric reporting and weekly task management. She assisted with system implementation, such as DartNet Patient Registry, Healthcare Access San Antonio HIE products, and iCentrix Clinical Decision Support System. Amanda facilitated local Health Information Exchange, the internal Information Technology department, and CiNow data evaluation involvement with waiver projects and other projects and grants. She also served as Project Manager for the Robert Wood Johnson D.A.S.H. (Data Across Sectors for Health) Grant and the Johnson & Johnson Grant on Integration of Physical Health Data and Services for Improved Health Outcomes for Adults with SMI and Co-occurring Substance Use Disorders.

Prior to her role as a Consultant, Amanda served as Manager of Program Planning and Implementation with CHCS. In this role, she was responsible for the development of grants and other funding, from researching and vetting through submission and initial implementation planning. She coordinated with internal and external partners to obtain and develop grant components and provided project management for awarded grants, including the HIE high-utilizer project, the Hogg Foundation Integrated Care data grant, 1115 Waiver projects and the CMS Integrated Behavioral Health Clinic on the Haven for Hope campus. Amanda developed and monitored organization-wide quality improvement initiatives and projects through effective dashboards designed to inform and facilitate achievement of established quality service and performance goals.

Previously, Amanda served as Grant Administrator for the Goldsbury Foundation in San Antonio, where she managed and maintained the grants management database. She was responsible for day-to-day grantmaking operations including correspondence, grant award letters and contracts, declinations and grant payments. Amanda also served as Senior Human Resources Manager at SBC IT Services, where she handled activities including managing timelines, benefits, communications, payroll, assets, finance, labor, regulatory and legal. Additional positions Amanda has held include Director of Project Management and Quality Assurance, Application Development Technical Director of Project Management, and Quality Assurance Manager of the Wireless Billing System at SBC IT Services (previously SBMS).

Amanda received her Bachelor of Business Administration from Texas A&M University.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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