HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 25, 2017

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE SPENDING IN 2016

This week, our *In Focus* section reviews Medicaid spending data collected in the annual CMS-64 Medicaid expenditure report. In federal fiscal year (FFY) 2016, Medicaid expenditures across all 50 states and 6 territories exceeded $548 billion, with nearly half of all spending now flowing through Medicaid managed care programs.

Total Medicaid Managed Care Spending

Total Medicaid managed care spending (including the federal and state share) in FFY 2016 across all 50 states and 6 territories was $269 billion, up from $238 billion in FFY 2015. This figure includes spending on comprehensive risk-based managed care programs as well as prepaid inpatient health plans (PIHPs) and

prepaid ambulatory health plans (PAHPs). PIHPs and PAHPs refer to non-comprehensive prepaid health plans that provide only certain services, such as dental services or behavioral health care. Fee-based programs such as primary care case management (PCCM) models are also counted in this total. However, comprehensive risk-based managed care organizations (MCOs) account for 95 percent of the total. Below we highlight some key observations:

- Total Medicaid managed care spending grew 13.1 percent in FFY 2016, the lowest year-over-year growth rate since FFY 2009.
- This slowing of spending growth, down from 27.8 percent and 31.2 percent in FFY 2014 and FFY 2015, respectively, is likely due to the deceleration of states expanding Medicaid after two years of significant activity.
- In dollar terms, the increase from FFY 2015 to FFY 2016 was $31.07 billion.
- Medicaid managed care spending has increased at an 18 percent compounded annual growth rate (CAGR) since FFY 2007, compared to 6.5 percent growth in total Medicaid spending.
- Medicaid managed care spending represented 49.1 percent of total Medicaid spending in FFY 2016. Since FFY 2009, the year prior to the passage of the Affordable Care Act (ACA), Medicaid managed care spending as a percentage of total Medicaid spending has nearly tripled.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures FFY 2007-2016 ($M)

$M	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	CAGR
Medicaid MCO expenditures*	$60,663	$71,318	$78,644	$90,394	$102,478	$120,325	$141,998	$181,421	$238,089	$269,161	**18.0%**
% y/y	*13.3%*	*17.6%*	*10.3%*	*14.9%*	*13.4%*	*17.4%*	*18.0%*	*27.8%*	*31.2%*	*13.1%*	
Total Medicaid expenditures	$311,014	$337,055	$356,285	$381,615	$406,459	$408,850	$432,944	$467,426	$525,772	$548,188	**6.5%**
% y/y	*4.0%*	*8.4%*	*5.7%*	*7.1%*	*6.5%*	*0.6%*	*5.9%*	*8.0%*	*12.5%*	*4.3%*	
% of Total	**19.5%**	**21.2%**	**22.1%**	**23.7%**	**25.2%**	**29.4%**	**32.8%**	**38.8%**	**45.3%**	**49.1%**	

**Includes Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans*

Source: CMS-64

The data breaks down the state and federal share of Medicaid expenditures, which illustrates the impact that the Medicaid expansion, which has been 100 percent federally funded in the states in which it has been adopted, has had on the sources of funding.

As the table below indicates, 63.1 percent of FFY 2016 spending was contributed by federal sources, which is 5.7 percentage points higher than the pre-Medicaid expansion share in FFY 2013.

Federal vs. States Share of Medicaid Expenditures, FFY 2012-2016

$M	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16
Federal Share	$235,070	$248,641	$281,269	$330,708	$346,325
% of Total	*57.5%*	*57.4%*	*60.2%*	*62.9%*	*63.2%*
State Share	$173,780	$184,303	$186,157	$195,063	$202,056
% of Total	*42.5%*	*42.6%*	*39.8%*	*37.1%*	*36.8%*
Total	**$408,850**	**$432,944**	**$467,426**	**$525,772**	**$548,382**

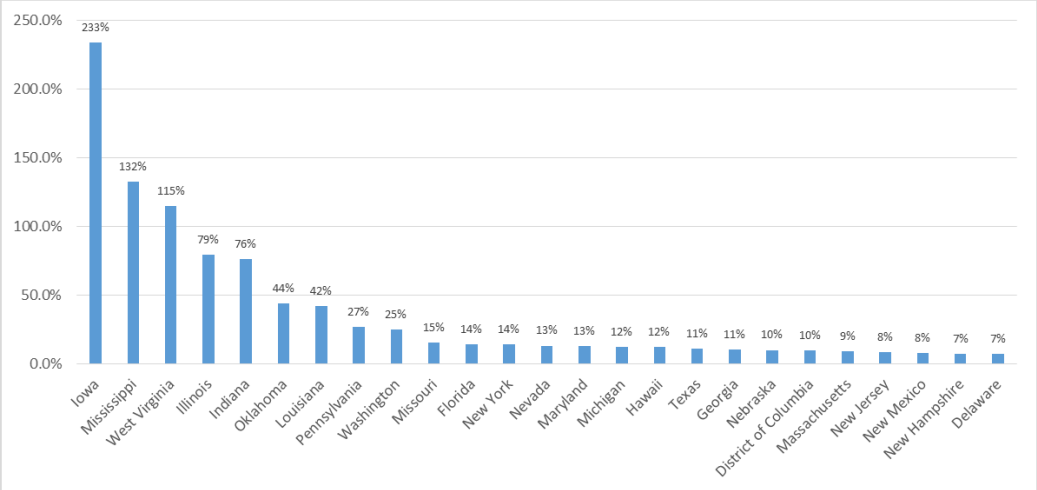
Source: CMS-64

State-specific Growth Trends

Fourty-four states report MCO spending on the CMS-64 report of which five states (Alabama, Idaho, North Carolina, Oklahoma and North Dakota) utilize a PCCM and/or PIHP/PAHP models exclusively. Of the remaining 39 states that contract with risk-based MCOs, average spending growth in FFY 2016 increased 24 percent. On a percentage basis, Iowa experienced the highest year-over-year growth in Medicaid managed care spending at 233 percent, which was attributable to the roll-out of its managed care program that began in April 2016. Mississippi, West Virginia, Illinois, and Indiana all saw Medicaid managed care spending growth of more than 75 percent, with Oklahoma and Louisiana growing more than 40 percent.

The chart below provides additional detail on Medicaid managed care spending growth in states with risk-based managed care programs in FFY 2015. Interestingly, all states experienced year over year growth in spending except Pennsylvania and Tennessee, which experienced very slight (<1 percent) reductions.

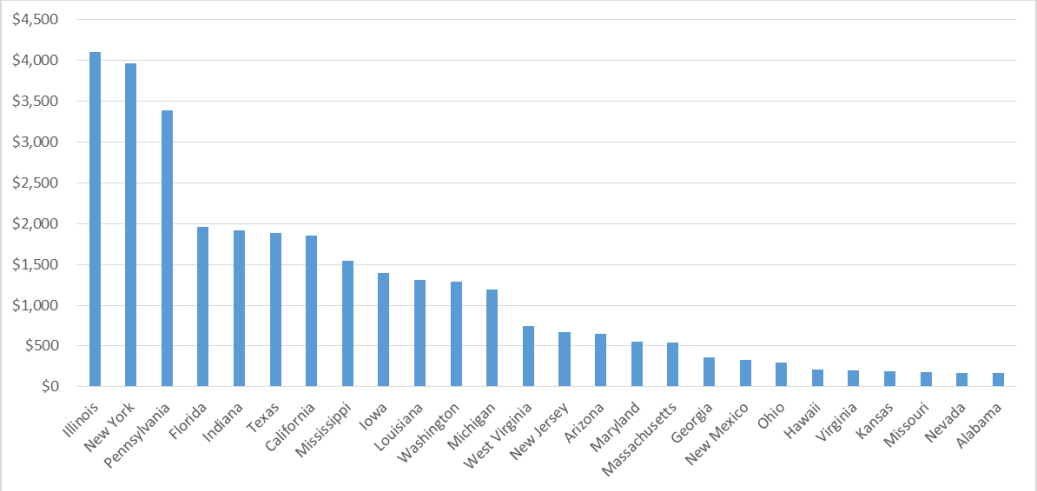
Medicaid Managed Care Spending Growth on a Percentage Basis by State FFY 2015-16



Source: CMS-64

Looking at year-over-year spending growth in dollar terms, Illinois' expansion of Medicaid managed care to roughly two-thirds of all Medicaid beneficiaries drove a $4 billion increase in managed care spending from FFY 2015 to FFY 2016. New York also saw growth just under $4 billion. Other states with significant year-over-year spending increases in dollar terms included Pennsylvania ($3.4 billion) and Florida ($1.9 billion). All other states saw year-over-year spending growth of less than $2 billion.

Medicaid Managed Care Spending Growth on a Dollar Basis by State FFY 2015-16 ($M)



Source: CMS-64

The percentage of Medicaid expenditures directed through risk-based Medicaid MCOs increased by more than 10 percentage points in seven states from FFY 2015 to FFY 2016. Iowa led the pack with a 28.9 percentage point increase to 42.3 percent of Medicaid spending, followed by a 27.5 percentage point increase in Mississippi and a 20.4 percentage point increase in West Virginia.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures in States with a 10 percent or Greater Increase From FFY 2015 to FFY 2016 ($M)

	FFY 2015				FFY 2016			
Medicaid Expenditures	MCO	Total	% of Total	Change in % of total	MCO	Total	% of Total	Pct. Point Change in % of total
Iowa	$598	$4,476	13.4%	1.1%	$1,994	$4,716	42.3%	28.9%
Mississippi	$1,169	$5,136	22.8%	5.8%	$2,715	$5,398	50.3%	27.5%
West Virginia	$652	$3,647	17.9%	0.1%	$1,399	$3,656	38.3%	20.4%
Illinois	$5,201	$16,938	30.7%	16.8%	$9,306	$19,179	48.5%	17.8%
Indiana	$2,524	$9,250	27.3%	6.8%	$4,444	$10,372	42.8%	15.6%
North Dakota	$91	$534	17.0%	15.6%	$88	$282	31.3%	14.2%
Louisiana	$3,139	$7,863	39.9%	17.3%	$4,451	$8,537	52.1%	12.2%
Washington	$5,230	$10,494	49.8%	5.8%	$6,517	$10,788	60.4%	10.6%

Source: CMS-64

The table below ranks the 39 states with risk-based comprehensive Medicaid managed care programs by the percentage of total Medicaid spending that is through Medicaid MCOs. Puerto Rico reported the highest such percentage at 97.9 percent, followed by Kansas at 93.1 percent and Hawaii at 88.9 percent. We note that in many states, there are certain payment mechanisms which may never be directed through managed care such as supplemental funding sources for institutional providers and spending on retroactively eligible beneficiaries. Thus, the maximum acheivable penetration rate in each state will vary and may be below that achieved in other states. Nevertheless, we note that there are a number of large states where the penetration rates are currently below two-thirds of the total enrollment that are committed to moving as much program administration and spending through managed care as they can. These include Michigan, New Jersey, Ohio, New York, California, Texas, and Illinois.

Accordingly, we expect that in FFY 2017 we will see continued growth in Medicaid MCO penetration, though likely at a more moderate pace.

Medicaid MCO Expenditures as a Percent of Total Medicaid Expenditures, FFY 2015-2016

Rank	State	2015	2016	Rank	State	2015	2016
1	Puerto Rico	99.3%	97.9%	21	Mississippi	22.8%	50.3%
2	Kansas	94.3%	93.1%	22	Texas	50.4%	49.0%
3	Hawaii	88.4%	89.9%	23	Illinois	30.7%	48.5%
4	Arizona	85.1%	87.1%	24	Wisconsin	45.2%	48.2%
5	Delaware	81.0%	85.8%	25	Minnesota	50.1%	46.7%
6	New Mexico	84.1%	83.6%	26	South Carolina	46.1%	46.5%
7	Florida	64.8%	72.4%	27	Maryland	45.1%	46.1%
8	Kentucky	71.9%	71.6%	28	Nevada	42.0%	44.2%
9	Michigan	61.6%	65.6%	29	Indiana	27.3%	42.8%
10	Tennessee	67.1%	64.7%	30	Iowa	13.4%	42.3%
11	Washington	49.8%	60.4%	31	New Hampshire	43.5%	41.2%
12	Oregon	60.9%	60.2%	32	Virginia	39.4%	39.6%
13	New Jersey	56.0%	59.6%	33	Georgia	35.6%	39.1%
14	Pennsylvania	54.8%	58.9%	34	West Virginia	17.9%	38.3%
15	Rhode Island	57.1%	57.5%	35	Massachusetts	38.3%	37.8%
16	Ohio	54.1%	55.1%	36	District of Columbia	38.5%	36.3%
17	New York	48.7%	52.7%	37	Nebraska	34.1%	35.2%
18	Louisiana	39.9%	52.1%	38	Missouri	12.0%	13.4%
19	Utah	49.3%	50.9%	39	Colorado	12.8%	12.1%
20	California	46.4%	50.6%				

Source: CMS-64

Non-MCO Expenditures

Despite the rapid growth in Medicaid managed care over the last ten years, program spending still represented just about half of total Medicaid expenditures in FFY 2016. So where is the remaining FFS spending (approximatley $279 billion) going? First, as noted above, there are many states/territorires with Medicaid managed care programs where certain beneficiaries or services are carved-out of the program, and these are typically associated with high-cost populations. The total amount of non-MCO spending in these 39 states in FFY 2016 was around $236 billion. If we were to assume for the sake of argument that "full penetration" was 85 percent of total Medicaid spending, then we estimate that an additional $161 billion in current FFS spending could shift to a managed care model just in the states that already employ managed care for a subset of services and/or beneficiaries.

Next, there are 17 states/territories that did not utilize a comprehensive risk-based managed care model in FFY 2016. Two of these states, Oklahoma and North Carolina, are planning to implement such a model in the next several years. In general, the 17 states/territories that do not utilize managed care today are smaller states, North Carolina being the largest at $12 billion of Medicaid spending in FFY 2016. Total Medicaid spending across all 17 non-managed care states was $46.2 billion. The 17 states/terrirtories that did not employ a risk-based comprehensive Medicaid managed care model in FFY 2016 were Alabama, Alaska, American Samoa, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Northern Mariana Islands, North Dakota, North Carolina, Oklahoma, South Dakota, Vermont, Virgin Islands and Wyoming.

Finally, in terms of spending by service line, the largest remaining fee-for-service (FFS) category is inpatient services, at $71 billion or 25.4 percent of FFS spending. This amount is split fairly evenly between regular FFS payments (47

percent of total) and supplemental/DSH funding sources (53 percent). Measured as whole, however, we estimate long term care services and supports (including nursing facility, waiver and other home and community based services) represent the largest FFS funding category, at $118 billion or 42.3 percent of the total.

Fee for Service Medicaid Expenditures by Service Line, FFY 2016

Service	FFY 2016 FFS Spending	% of Total FFS Spending
Inpatient Services*	$70,958	25.4%
Home and Community Based Services	$50,516	18.1%
Nursing Facility*	$43,850	15.7%
Outpatient Services*	$15,130	5.4%
Medicare - Part B	$10,586	3.8%
Physician and Surgical Services*	$9,890	3.5%
Intermediate Care	$9,767	3.5%
Personal Care Services	$7,532	2.7%
Clinic Services	$5,011	1.8%
Federally-Qualified Health Center	$4,313	1.5%
Dental Services	$4,199	1.5%
Other	$47,467	17.0%
Total	**$279,220**	**100%**

** Includes regular payments, supplemental payments and DSH if applicable*

Source: CMS-64

Finally, we note that while the CMS-64 report provides valuable detail by service line for all FFS expenditures, it does not capture how spending directed to Medicaid MCOs is allocated by category of service. As such, it is not possible to calculate total spending by service line, a challenge that will only intensify as more spending runs through MCOs.

HMA Medicaid Roundup

Arizona

CMS Approves AHCCCS Targeted Investments Program. The Arizona Health Care Cost Containment System (AHCCCS) announced on January 18, 2017, that the Centers for Medicare & Medicaid Services (CMS) has approved its request to implement a Targeted Investments Program. The program will direct Medicaid managed care plans to make specific payments to providers for the promotion of physical and behavioral health integration, efficient delivery of care, and improved health outcomes. The program is expected to make $300 million in payments available over five years. The program will also focus on assisting AHCCCS members who have transitioned into the community from criminal justice facilities by connecting the individuals to acute and behavioral health care services upon release. For more information, please see the AHCCCS General News section here.

AHCCCS Releases Integrated Contractors RFI Ahead of Acute Care/CRS Reprocurement. The Arizona Health Care Cost Containment System (AHCCCS) released a request for information (RFI) on January 24, 2017, for Integrated Contractors to offer fully integrated behavioral and physical health services to children and adult Medicaid members as part of the upcoming reprocurement of the Acute Care and Children's Rehabilitative Services (CRS) Medicaid managed care program. The Acute Care/CRS request for proposals is anticipated to be released November 2, 2017, with proposals due January 25, 2018, and an anticipated implementation date of October 2018. As of year-end 2016, there were 1.6 million Medicaid members enrolled in Acute/CRS Medicaid managed care plans. Read More

California

HMA Roundup – Julia Elitzer (Email Julia)

Gardens Regional Hospital Closed After Deal Falls Through. *Beckers Hospital Review* reported on January 18, 2017, that Gardens Regional Hospital and Medical Center closed. Gardens Regional was a 137—bed nonprofit hospital in Hawaiian Gardens, California. The proposed sale to Riverside, CA-based Strategic Global Management Inc. (SGM) fell through over a provision that required SGM to provide $2.25 million per year for charity care over six years and pay $2.4 million under the Hospital Quality Assurance Fee. Read More

Medi-Cal Accounting Error Drives Budget Deficit Projection. *FOX News* reported on January 18, 2017, that California Governor Jerry Brown's administration announced a $1.9 billion Medi-Cal accounting error, which along with lower than expected tax revenues has resulted in a projected budget deficit

for fiscal 2018. The error was discovered last fall and included the failure to account for drug rebates owed by the state and the miscalculation of costs in the state's Coordinated Care Initiative. Brown is proposing the elimination of CCI; however, counties say that would only shift the costs to them. Read More

State Withdraws Request to Sell Unsubsidized Exchange Policies to Immigrants. *The New York Times* reported on January 18, 2017, that California state officials have withdrawn a request to waive the federal requirement prohibiting immigrants who are undocumented from receiving unsubsidized insurance on the state's Exchange, Covered California. The state's decision is likely tied to the inability to receive approval of the request prior to the transition to President-elect Donald Trump's administration. Read More

Connecticut

Providers Suggest Privatizing Services for Individuals with Mental Illness, I/DD. *The CT Mirror* reported on January 18, 2017, that not-for-profit social services providers in Connecticut are proposing the privatization of certain services for individuals with mental illness and intellectual and developmental disabilities (I/DD). Providers are hoping to avoid a 10 percent cut in state funding and likely layoffs, noting that privatization could save the state more than $1.3 billion. Many state employees' unions have clauses in their contracts prohibiting layoffs in the event of privatization, and SEIU 1199 New England has a pending lawsuit preventing such layoffs. Connecticut provides residential support at state-run facilities for individuals with developmental disabilities. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Medicaid HMO to Rebate Percentage of Profits to the State. *Politico* reported on January 25, 2017, that a Florida Medicaid HMO will need to rebate a portion of its profits to the state under the Florida Achieved Savings Rebate law, which is designed to prevent health plans from achieving excessive profits from Medicaid. The rebate is established by determining pretax income as a percentage of revenues, with plans required to make payments if profit margins exceed 5 percent of revenues. Plans are also required to maintain an 85 percent medical loss ratio, which every plan in the state met, an official said. The plan and amount to be repaid has not been made public. Read More

Governor Takes Aim at Certificate of Need Process, Trauma Center Limits. *Sayfie Review* reported on January 24, 2017, that Florida Governor Rick Scott wants to eliminate the certificate of need (CON) process for the construction of hospitals, nursing homes, and hospices. The Governor also indicates he wants to end limits on the opening of additional trauma centers in the state. The hospital industry has favored eliminating the CON process, claiming it would expand access and increase competition. Under the CON process, the Florida Agency for Health Care Administration reviews proposed health care projects and determines whether they should be allowed to move forward. Read More

Iowa

Number of Uninsured Could Rise by 230,000 Following ACA Repeal. *Business Record* reported on January 19, 2017, that approximately 230,000 Iowa residents would potentially lose health insurance coverage by 2019 if the Affordable Care Act (ACA) is repealed, according to an Iowa Fiscal Partnership Policy Brief. About 42,000 of the 230,000 are ACA Exchange members, with the remaining 188,000 covered under Medicaid expansion. The report adds that the total amount of uncompensated care in Iowa in 2019 would more than triple to $1.2 billion. Read More

Kansas

KanCare Waiver Extension Denied by CMS. *The Wichita Eagle* reported on January 19, 2017, that the Centers for Medicare & Medicaid Services (CMS) denied a request from Kansas to extend the state's KanCare 1115 waiver, under which the statewide Medicaid managed care program operates. In its response to the state, CMS said KanCare was "substantively out of compliance with Federal statutes and regulations," adding that the state failed to provide effective oversight and jeopardized the health of members. The KanCare waiver is currently authorized through the end of 2017; the state was requesting a one year extension through the end of 2018. Kansas must provide CMS with a corrective action plan by February 17, 2017. Read More

Officials Defend KanCare After CMS Denies Waiver Renewal. *The Kansas City Star* reported on January 23, 2017, that Kansas officials are defending the state's KanCare Medicaid managed care program, despite a review from federal regulators that claimed the program lacked transparency, was out of compliance with federal standards, and posed risks to patients. The Centers for Medicare & Medicaid Services (CMS) issued the findings in denying a state request to renew the KanCare 1115 waiver through 2018. Kansas Department of Health and Environment Secretary Susan Mosier argued that the review made "statements of opinion rather than statements of fact." Read More

Medicaid Application Backlog Forces Dental Provider to Suspend Care. *KCUR.org* reported on January 24, 2017, that lack of payment stemming from the Kansas Medicaid application backlog has caused dental services provider Sterling Dental to suspend services for pending Medicaid applicants. Sterling Dental provides dentists to nursing homes in Oklahoma, Missouri, and Kansas for on-site care. Kansas Department of Health and Environment Secretary Susan Mosier said that the state will soon provide webinar training for nursing home staff to help expedite the application process. Read More

Maryland

Maryland Begins Enrolling Former Inmates in Medicaid. *The Baltimore Sun* reported on January 24, 2017, that Maryland officials at the Department of Public Safety and Correctional Services are starting to enroll former inmates in the state's Medicaid program in anticipation of federal approval of a correctional program waiver, which goes live on July 1, that would allow everyone in the correctional system to be enrolled in Medicaid upon release. The state is currently signing up approximately 150 former inmates a month. Read More

State Could Lose $2 Billion in Medicaid Funding Under ACA Repeal. *The Baltimore Sun* reported on January 19, 2017, that Maryland could stand to lose $2 billion in federal Medicaid funding if the Affordable Care Act (ACA) is repealed, according to legislative analysts speaking before the Maryland House Health and Government Operations Committee. Hospitals could lose an additional $2.3 billion in annual funds. Since the ACA's implementation, Maryland's uninsured rate decreased from 10 percent to 6.7 percent, with more than 400,000 people obtaining coverage through Medicaid expansion or the Exchange. Legislative analysts also noted that uncompensated care in the state declined by $311 million from 2013 to 2015. Read More

Minnesota

Governor Proposes Public Option, Urges Action on Exchange Premium Relief. *GrandRapidsMN.com* reported on January 24, 2017, that Minnesota Governor Mark Dayton is proposing a public health insurance option, which would be based on the MinnesotaCare program for low-income individuals who don't qualify for Medicaid. The program would have to be enacted by April 1, 2017, for a start date of January 1, 2018, and would require federal approval. Meanwhile, Governor Dayton is urging legislators to pass legislation to provide premium relief to individuals who purchase coverage on the Exchange but don't receive subsidies. Read More

Legislation to Help People Pay Exchange Plan Premiums Moves Ahead. *Duluth News Tribune* reported on January 19, 2017, that the Minnesota legislators are working to iron out differences in legislation that would set aside $300 million to help approximately 120,000 Minnesotans who buy health coverage on the Exchanges, but do not qualify for federal subsidies. Both the Minnesota House and Senate have passed versions of the bill. One key sticking point is whether health plans or the state will administer the new funds. Additionally, the legislation would allow insurers to operate for-profit health maintenance organizations (HMOs) in Minnesota, including plans owned by out-of-state companies. Under the current law, only Minnesota-based not-for-profit HMOs are permitted to operate in the state. Read More

Special Needs BasicCare Contracts Fully Implemented as of January 2017. As of January 1, 2017, Minnesota's Department of Human Services (DHS) has fully implemented Special Needs BasicCare (SNBC) contracts as a result of a procurement issued in February 2016. The state's two primary goals under the procurement were to replace Medica in the counties the plan announced it would exit as of July 2016 and to increase coordination of Medicaid and Medicare for dual eligible members. The SNBC program is a voluntary Medicaid managed care program for individuals who have a disability and are eligible for medical assistance through Medicaid in all 87 counties statewide. Enrollees who turn 65 may choose to stay in the program, and any enrollee may opt out of the program at any time. The six Special Needs BasicCare plans under contract are UCare, HealthPartners, PrimeWest Health, South Country Health Alliance, Medica, and Hennepin Health. In certain plans, enrollees who are dual eligible may opt to integrate their Medicare benefits through their SNBC plan. Medicare integration is available in 36 out of 87 counties. Medicare integration is an option in all PrimeWest Health and South Country Health Alliance plans, as well as an option for UCare members in 11 counties. As of January 2017, there are more than 50,300 SNBC members enrolled.

Medica Lays Off Workers Leading up to End of Medicaid Contract. *Bizjournals.com* reported on January 17, 2017, that Minnesota health insurer Medica has eliminated 100 full time jobs, approximately five percent of its workforce, leading up to the expiration of its contract to provide Medicaid services on April 30, 2017. The insurer chose to withdraw from most of its Medicaid contracts last fall, stating that Medicaid rates were not generating enough revenue to offset to costs. Medica was one of several insurers that won contracts in 2015 as a result of a competitive bidding process. Read More

Mississippi

Division of Medicaid Requests $88.9 Million to Close Budget Gap. *DJournal.com* reported on January 19, 2017, that the Mississippi Division of Medicaid is requesting an $88.9 million deficit appropriation to close a budget gap. This is an increase over the $75 million deficit appropriation request made in the fall of 2016. The increased request came after Mississippi Governor Phil Bryant announced a 1.4 percent statewide budget cut, resulting in a reduction of $13.9 million for Medicaid. Without additional funds, Medicaid could be forced to consider cuts to services and provider reimbursements. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Auditor Report Determines DMAHS Fails to Monitor Medicaid Network Adequacy. On January 24, 2017, the New Jersey Office of the State Auditor released a report on the audit of the Division of Medical Assistance and Human Services (DMAHS). The report detailed the State Auditor's findings and conclusions that DMAHS does not effectively monitor the adequacy of provider networks of the five Managed Care Organizations (MCOs) in terms of access to care and provider availability. DMAHS concurs with the report's findings. The report also included recommendations to DMAHS. Key findings and recommendations from the Audit Report include:

- Four of the five MCOs misreported the total number of facilities as general acute care hospitals to make it appear that the MCOs met contracting requirements and Medicaid beneficiaries had appropriate access to hospitals when they did not.

  State Auditor's Recommendation: Enforce contracting requirements and ensure Medicaid beneficiaries have access to general acute hospitals

- Reviewing the two largest MCOs, the Office of the State Auditor uncovered that many dentists and primary care physicians (PCP) are not practicing in the locations listed in the Geo Access Reports.

  State Auditor's Recommendation: Work with the MCOs to ensure beneficiaries have access to care

- The MCOs' online provider directories do not accurately reflect provider information. Of the 251 specialist providers reviewed, 65 (25.9%) of those providers are not at the locations listed on the directories and 21 (11.3%) are not accepting the MCOs' insurance.

State Auditor's Recommendation to DMAHS: Verify MCOs' online provider directories are accurate

- DMAHS failed to request claims inactivity reports from the MCOs, which would have enhanced their ability to monitor the MCO provider networks. The PCP networks of three MCOs were not meeting the claims inactivity criteria for the year.

  State Auditor's Recommendation: Require MCOs submit claims inactivity reports

- PCP's panel sizes exceed contractual limits, which can reduce the physicians' availability and the beneficiaries' access to care.

  State Auditor's Recommendation: Prohibit providers from accepting new beneficiaries when their panel sizes exceed the standards

Read More

Out-Of-Network Billing Forum Scheduled. *NJSpotlight* will convene a panel of legislative and industry leaders on January 27, 2017, to discuss the ongoing issues about surprise medical bills from out-of-network providers. The session will be held from 8:30 – 11:00 am at The War Memorial in Trenton. Attendance is free, but registration is required and possible through the www.njspotlight.com website.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Executive Budget Proposal. Governor Cuomo introduced his FY 2018 executive budget proposal totaling $152.3 billion, an increase of 3.4 percent over the current budget. State Operating Funds increase by 1.9 percent, consistent with the governor's self-imposed spending cap of 2 percent. Medicaid spending, including the local share and funds from other state agencies, is projected to be $65.15 billion, an increase of $2 billion or 3.17 percent over current year spending.

- ***Global Cap*** - The Executive proposes extending the state Medicaid Global Cap for one year through FY 2019. The Global Cap limits DOH Medicaid spending growth to the 10-year average of the Medical component of the Consumer Price Index (CPI), which is currently estimated at 3.2 percent. The budget also includes language that would allow the governor to suspend the global cap in the case of changes to the availability of federal financial participation in Medicaid expenditures or changes in federal Medicaid eligibility.

- ***Minimum Wage Increases*** - The FY 2017 Enacted Budget included funding for the minimum wage totaling $44 million. The FY 2018 Executive Budget includes $255 million to support costs of the minimum wage. These funds are allocated to implement new minimum wage requirements and will be used to support direct salary costs and fringe benefits for health care workers reimbursed by the Medicaid program.

- ***Pharmacy Initiatives*** – The budget proposes price ceilings for high-cost prescription drugs. It would impose a 100 percent supplemental rebate for any amount that exceeds a benchmark price recommended by the

Drug Utilization Review Board. The budget also proposes the elimination of "prescriber prevails" for all drugs except atypical antipsychotics and antidepressants. Finally, the budget proposes a licensure requirement for pharmacy benefits managers, including requiring that they report any potential conflicts of interest.

- ***Managed Long-Term Care*** – The budget would require that new enrollees into managed long-term care plans meet the nursing facility level of care, rather than just requiring more than 120 days of community-based long-term care, effectively pushing some long-term care back to mainstream managed care plans. It also includes an $18 million/year cut to nursing home rates, and a reduction in the bonuses plans can receive for meeting certain quality measures.
- ***Basic Health Program*** – the budget extends premiums for the Essential Plan, New York's Basic Health Program, to individuals between 138 percent and 150 percent of the federal poverty level; they currently apply to those between 150 percent and 200 percent FPL.
- ***Capital Spending*** – The budget extends this year's capital program for health care facilities. The language is identical to last year's health care facility transformation program, and includes $500 million in spending, of which at least $30 million is earmarked for community-based health care providers. Under the proposal the state is not required to do a competitive bid or RFP; the commissioner can choose to award all or a portion of the funds to applications that were submitted as part of last year's Health Care Facility Transformation Program. Of the $500 million, $50 million is earmarked for Montefiore Medical Center.
- ***Health Care Regulation*** – The budget proposal establishes a health care regulation modernization team, which is meant to review a whole host of regulations governing licensure and oversight of health care facilities. The goals are to increase the speed with which providers can complete construction projects; support the delivery of services across an integrated system of care; modernize regulations that ensure access and protect patient safety; and enhance collaboration between the state and health care providers. The stakeholder group are required to develop recommendations before the end of the year.
- ***Consolidation and Cuts to Public Health Programs*** – The budget proposes consolidating 39 different public health awareness and prevention programs, including disease prevention, maternal and child health, workforce support, and programs that serve health care needs of individuals, into four pools and reducing funding by 20 percent.

New White Board on Value-Based Payment. The Department of Health has released a new White Board video addressing myths and facts about New York's value-based payment (VBP) initiative. Jason Helgerson, the state's Medicaid director, reviewed a number of misperceptions about the initiative. The state does not expect all providers to reach level three value-based payment initiatives (full capitation); lower level arrangements including shared savings can generate important innovation. The goal of the program is not to cut costs but to generate savings for reinvestment. The intent of VBP is not to reduce health care networks but to move the health care delivery system toward a more patient-centered system. Helgerson also identified a number of facts about the

program. It is not optional – the terms and conditions of New York's 1115 Medicaid waiver require the state to move to VBP. The state is providing access to its Medicaid data warehouse to facilitate data analytics supporting the move to VBP. An explicit goal of the VBP initiative is to shift spending out of institutions and into community-based settings. Finally, the program intends to increase transparency around cost and quality, identifying variation that spotlights high-value care. This White Board and all previous ones can be found on the state's Delivery System Reform Incentive Payment website. Read More

New York Opts Not to Renew Contract with LogistiCare, Pending Active Protest. *Crain's HealthPulse* reported on January 23, 2017, that New York has opted not to renew its contract with LogistiCare Solutions, a company that coordinates non-emergency transportation to and from medical appointments for Medicaid beneficiaries. LogistiCare is actively protesting the decision and its contract will be extended until April 22 while the state comptroller considers the company's objections to being replaced. The company holds a three-year, $168 million contract to provide services in New York City. The Department of Health intends to extend its contract with Medical Answering Services, which already serves the rest of the state, aside from Long Island. Read More

North Carolina

Senior Advocates Push to End PACE Moratorium. *North Carolina Health News* reported on January 18, 2017, that North Carolina advocates are pushing to end a moratorium on new Program of All-inclusive Care for the Elderly (PACE) programs, as well as ending enrollment caps for existing PACE plans. Since 2014, no new PACE programs have been established, and existing PACE programs can only enroll three new participants per month. According to the North Carolina Department of Health and Human Services, PACE has come in under budget for the past two fiscal years, and as of November 30, 2016, was under budget for fiscal year 2016-17 as well. The North Carolina PACE association believes the programs can save the state as much as $18,400 per person, largely through avoidable nursing home admissions. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

2016 Annual Opioid Report Showing Large Decreases in Dispensing from 2012. The Ohio State Board of Pharmacy has released the 2016 Annual Report on the Ohio Automated Rx Reporting System. Highlights of the statutorily required report include:

- total doses of opioids dispensed to Ohio patients decreased by 162 million doses (or 20.4 percent) from 2012 to 2016;
- the total number of opioid prescriptions issued to Ohio patients decreased by 2.5 million (or 20 percent) between 2012 and 2016; and
- the total doses of benzodiazepines dispensed to Ohio patients decreased by 43 million doses (or 14.5 percent) from 2012 to 2016.

Additionally, the report found a 78.2 percent decrease in the number of individuals who see multiple prescribers to obtain controlled substances illicitly (commonly referred to as "doctor shopping") between 2012 and 2016. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Transportation Program Grant Funding to Primary Contractors. Pennsylvania's Department of Human Services announced how grant funding for the Medical Assistance Transportation Program (MATP) is disbursed to primary contractors when county governments elect not to administer MATP. MATP handles nonemergency medical transportation. Comments on the notice should be submitted to DHS within 30 days. Read More

Budget Deficit Could Double, 1.1 Million Could Lose Coverage Under ACA Repeal. *Philly.com* reported on January 19, 2017, that budget deficits in Pennsylvania could double and 1.1 million residents could lose health insurance coverage under a repeal of the Affordable Care Act (ACA), according to a report titled "Devastation, Death, and Deficits" by the Pennsylvania Budget and Policy Center. The report also projects an increase in premature deaths, a substantial decline in hospital revenues, and the loss of 137,000 jobs across the state. Read More

Rhode Island

Budget Proposal Freezes Rates for Hospitals, Nursing Homes, Cuts MCO Administrative Rates. *The Providence Journal* reported on January 19, 2017, that a proposed fiscal year 2018 budget from Rhode Island Governor Gina Raimondo would freeze Medicaid reimbursement rates for hospitals and nursing homes in 2017, followed by a 1 percent rate reduction beginning January 1, 2018. Additionally, the Governor's proposed budget would reduce the administrative rate paid to the state's contracted managed care organizations (MCOs). Read More

Texas

Attorney General Accuses CVS of Improper Medicaid Billing. *My Statesman* reported on January 18, 2017, that the Texas Attorney General is accusing CVS of improperly billing Medicaid $128 million to $130 million. While several other pharmacies have been accused of overbilling and have settled, CVS filed a lawsuit in December 2016 after five years of negotiations arguing that the state Medicaid agency approved the prices being questioned. The state responded by filing a lawsuit accusing CVS of fraudulent reimbursements dating back to 2005. The lawsuit emerged after a five-year investigation suggested that CVS inflated prices through its Health Savings Pass program. CVS could be banned from the state's Medicaid program for 10 years if it loses at trial. Read More

Virginia

New Approach to Setting Reimbursements for Providers Serving People with Disabilities Receives Criticism. *Richmond Times-Dispatch* reported on January 22, 2017, that Virginia is taking criticism for changes in the way it determines reimbursement levels for Medicaid providers serving individuals with disabilities. The state is using the Supports Intensity Scale (SIS) to determine

reimbursement level. Previously SIS was only used to determine the particular level of care required, while reimbursement levels were determined by the type of Medicaid waiver program a person was enrolled in. The change comes as part of a larger redesign of the state's Medicaid waiver system. Advocates are concerned the new approach does not accurately capture individuals' needs and may lead to higher rates of institutionalization. Virginia regulators say the assessment will allow the state to more appropriately distribute funds and reduce waiting lists. Read More

Wisconsin

DHS Announces Awards for Family Care MLTSS in Expanded Counties. The Wisconsin Department of Health Services (DHS) announced on January 23, 2017, that three managed care companies have been selected to provide services under the Family Care managed long term services and supports (MLTSS) program in the state's expanded northern counties beginning in July 2017. Community Link will serve members in Oneida, Vilas, Florence, Forest, Taylor, and Adams counties. Lakeland Care will serve members in Oneida, Vilas, Florence, and Forest counties. Care Wisconsin will serve members in Taylor and Adams counties. The department expects full statewide transition to Family Care and IRIS in the first quarter of 2018. Read More

National

Medicaid FFS Providers May See Rise in Rates, Volume as Result of Access Assessments. *Modern Healthcare* reported on January 24, 2017, that Medicaid provider reimbursement rates or volume could rise as a result of states assessing the adequacy of access to care in Medicaid fee-for-service (FFS) programs. State access assessments are mandated under a 2015 Centers for Medicare & Medicaid Services (CMS) rule for primary care, pre- and post-natal obstetric services, specialists, behavioral health experts, and other services. If CMS finds access problems, the state will have 90 days to submit a corrective plan and a year to fix the problem. According to the Robert Wood Johnson Foundation, Medicaid FFS programs attract a disproportionate number of elderly members and individuals with disabilities or other complex health care needs, who may have trouble accessing providers, specifically specialists. Read More

Few States Reporting Budget Surpluses, Most Facing Shortfalls. *The PEW Charitable Trusts* reported on January 24, 2017, that California, Georgia, Idaho, and Utah are among a handful of states in good financial shape heading into this year's legislative sessions. These states were able to achieve budget surplus by avoiding deep tax cuts, enacting targeted tax increases, diverting some surplus money into "rainy day" funds, and not relying on a single revenue source. In California, Governor Jerry Brown is proposing to slow school spending growth and roll back a series of one-time expenses to close a projected $1.6 billion gap. Meanwhile, Georgia resisted cutting taxes and is diverting excess amounts to the state's rainy day fund. At least 31 states, however, are facing budget shortfalls, according to MultiState Associates Inc. The National Association of State Budget Officers predicts revenues in fiscal 2017 will come in below projections in 24 states, on target in 16 states, and above forecast in only four states. Read More

President Signs Executive Order that Could Impact ACA Individual Mandate. *Associated Press* reported on January 21, 2017, that President Trump signed an executive order on his first day of office allowing federal agencies to grant waivers, exemptions, and delays related to provisions of the Affordable Care Act (ACA). The order focuses on provisions that impose costs on individuals or states, including the "individual mandate" requirement that all individuals have insurance or be assessed a penalty. It is unclear at this time, however, if the Internal Revenue Service can waive the individual mandate penalties in 2017. The order also directs agencies to stop issuing regulations that would expand the ACA. While the President's order does not directly target the Exchanges, some are speculating that if healthy individuals are no longer required to purchase coverage, insurers could pull out of Exchange markets in anticipation of higher costs. Read More

President, Lawmakers Work on ACA Repeal; Health Industry Lobbies Against ACA Taxes. *Modern Healthcare* reported on January 23, 2017, that President Trump and Republican members of Congress continue to work on an Affordable Care Act (ACA) repeal plan. Meanwhile, health care industry groups are lobbying hard to end taxes used to fund the ACA's premium and cost-sharing subsidies and Medicaid expansion, among other things. The Congressional Budget Office estimated that repealing the financing provisions would reduce federal revenues by nearly $1.2 trillion over a decade, which could severely hamper funding for an ACA replacement. Read More

HHS Nominee Price Supports Medicaid Premiums, Copayments. *Forbes* reported on January 22, 2017, that Secretary of Health and Human Services nominee Tom Price supports requiring Medicaid beneficiaries to pay premiums or copayments. During his first two Senate committee hearings, Price stated that he favors repealing Medicaid expansion and supports Indiana's plan requiring some enrollees to assume some financial responsibility as a prerequisite for Medicaid coverage. Read More

Medicaid Access May Not Be Guaranteed Under Block Grants, Says HHS Nominee. *NBC-2* reported on January 24, 2017, that U.S. Department of Health & Human Services (HHS) Secretary nominee Tom Price said Medicaid may no longer be an entitlement for under the block grant plan. During confirmation hearings, Representative Price said the federal government should leave it to the states to decide how to cover their residents. Under block grants, states would receive a fixed sum of federal funding to cover Medicaid members and would be allowed greater freedom in how they implement the funding. Read More

Trump Health Plan Favors Medicaid Block Grants. *The New York Times* reported on January 22, 2017, that President Trump will propose Medicaid blocks grants as part of his plan to replace the Affordable Care Act, according to adviser Kellyanne Conway. She said that block grants would "cut out fraud, waste, and abuse." Congress would need to decide how much funding each state would receive and how it would be adjusted for population changes, inflation, and rising medical costs. Read More

Republican Lawmakers Divided Over Medicaid Block Grant Design. *Politico* reported on January 23, 2017, that Republican lawmakers are divided over the seemingly impossible task of how to shift Medicaid funding to block grants while maintaining healthcare coverage for 11 million Medicaid expansion members. President Trump has indicated he supports Medicaid block grants, which cap funding but give more control to states. However, Trump has also

indicated he wants to ensure coverage for everyone. Details on block grant design and further Medicaid reforms should take shape as Congress looks to pass a repeal and replace bill in the coming months. Read More

Governors in Non-Expansion States Hoping for Congressional Flexibility in Future Coverage Options. *The Seattle Times* reported on January 19, 2017, that many Republican governors who have not expanded Medicaid in their states are hoping Congress will provide new avenues to provide insurance to individuals who are uninsured and have lower incomes. Many of the governors in these 19 states have indicated interest in block grants for Medicaid, as well as greater flexibility in how Medicaid funds may be used. However, some are expressing concerns that that funding could be based on 2016 enrollment levels, potentially disadvantaging states that did not expand Medicaid. Read More

Industry News

U.S. District Judge Blocks Aetna, Humana Merger. *The Wall Street Journal* reported on January 23, 2017, that U.S. District Judge John D. Bates blocked a merger between health insurers Aetna Inc. and Humana Inc., citing antitrust issues. The ruling states that the merger would increase prices and could negatively impact consumers in Medicare Advantage plans. An Aetna spokesman said that the company is considering appealing the ruling. Read More

U.S. District Court Judge May Block Anthem, Cigna Merger. *New York Post* reported on January 19, 2017, that U.S. District Judge Amy Berman Jackson is expected to block the proposed merger of health insurers Anthem Inc. and Cigna Corp. In a trial that ended January 4, 2017, Judge Jackson sided with the U.S. Department of Justice (DOJ), arguing that the deal would inhibit competition and increase insurance premiums for consumers. The DOJ, as well as both Anthem and Cigna, declined to comment. Read More

Maryland Co-op Evergreen Health Finalizes Investment Deal, Seeks For-Profit Status. *Bizjournals.com* reported on January 18, 2017, that Maryland-based Evergreen Health Cooperative announced that it has finalized a deal with investors with the goal of converting to for-profit status, ending its ties to the federal co-op program authorized under the Affordable Care Act (ACA). The investment will allow Evergreen to repay approximately half of the $60 million in loans it received under the ACA. The move brings Evergreen one step closer to a for-profit conversion, which requires state approval. Read More

Continuum Health Alliance Acquires Controlling Stake in Partners in Care. *Philly.com* reported on January 23, 2017, that Continuum Health Alliance, a New Jersey-based physician services company, has acquired a controlling stake in Partners in Care. The deal adds 600 physicians to Continuum's network and expands the company's presence in central New Jersey. Price was not disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February 16, 2017	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
February 21, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	RFP Release	83,000
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
February, 2017	Rhode Island	Implementation	231,000
Early 2017	MississippiCAN	RFP Release	500,000
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
Summer 2017	MississippiCAN	Contract Awards	500,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	83,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
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
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
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
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	83,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

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 News

Announcing the HMAIS Business Partner Showcase

HMA Information Services (HMAIS) is already the managed care industry's leading information resource for up-to-date data and procurement documents on Medicaid programs in all 50 states and the District of Columbia. **Now we're announcing our new Business Partner Showcase, a special program allowing Business Partners to post product literature, press releases, company brochures, white papers, sales contacts, and other promotional materials right on the HMAIS website**. We'll also help distribute your press releases and product announcements to our entire list of readers.

1. The HMAIS subscription database has more than 1,000 readers at leading Medicaid managed care plans nationwide. These are top executives and key decision makers who rely on HMAIS content for strategic planning, competitive assessment, operations, and development.

   The Business Partner Showcase puts your literature right in front of this important audience of Medicaid managed care decision makers. Your company gets a dedicated page in the HMAIS Business Partner section, where you can include all your relevant literature. All you need to do is provide us with the materials, and we'll load them onto the site.

2. Another 25,000 key industry contacts read HMA's free Weekly Roundup of Medicaid news and information. Any time you have an announcement, we'll include a headline and link to your press release in the Industry News section of the Weekly Roundup. This highly respected and well-read publication will enhance awareness of your products and services.

3. Finally, you get unlimited access to the HMAIS Medicaid database for every current employee of your organization. HMAIS is a widely used repository of information about each state's Medicaid program, including Medicaid managed care enrollment, financials, utilization, procurements, MLRs, and a Public Documents Library of Medicaid RFPs, responses, model contracts, scoring sheets, and more.

For additional information and to see a demonstration of HMAIS, contact Carl Mercurio at (212) 575-5929 or cmercurio@healthmanagement.com

Note: Certain restrictions apply. Neither HMAIS nor any of its affiliated companies (including HMA) endorse or recommend any commercial products, processes or services. Therefore, any mention of products, processes or services in the Service or on any HMAIS or HMA-related website is not an endorsement or recommendation. Further, neither HMAIS nor any of its affiliated companies (including HMA) control or guarantee the currency, accuracy, relevance or completeness of information found on linked external websites.

HMA's Ellen Breslin to Present at World Congress Workshop

February 27, 2017
Arlington, Virginia

The World Congress 10th Annual Medicaid Managed Care Summit coming up on February 27-28, 2017. Visit www.worldcongress.com/MMC for more information.

Upcoming Webinar: *"Relationship-Centered Care: A Healthcare Provider's Guide to Patient Engagement, Shared Decision Making, and Improved Outcomes"*

Thursday, February 16, 2017
1 to 2 p.m. EST

Relationship-centered care is more than just a good bedside manner. It's an entire primary and behavioral care construct designed to foster patient engagement, shared decision making, and a deep collaborative approach between healthcare providers and patients. During this webinar, HMA experts Margaret Kirkegaard, MD, Family Physician, and Jeffrey Ring, PhD, Health Psychologist, will provide a deep appreciation of the value of relationships in the provision of medical care, including data that illustrates the efficacy of the relationship-centered approach. The webinar will also provide a roadmap for provider organizations striving to enhance relationship-centered care initiatives that involve providers, patients, and the entire medical and administrative staff. Link to Registration