HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 1, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

- IN FOCUS: INDIANA SUBMITS HIP 2.0 WAIVER RENEWAL
- ALABAMA MEDICAID SEEKS ADDITIONAL FUNDING FOR RCO ROLL-OUT
- FLORIDA GOVERNOR PROPOSES HOSPITAL PAYMENT CUTS
- NEW JERSEY PROVIDES UPDATE ON MLTSS SPENDING
- NEW YORK DOH PROVIDES DSRIP PROGRAM UPDATE
- OHIO GOVERNOR'S PROPOSED BUDGET EXPANDS MLTSS
- PENNSYLVANIA GOV. PROPOSES CONSOLIDATION OF HEALTH AGENCIES
- CMS OFFERS TO EXTEND DUAL DEMOS IN MA, MN, WA
- KINDRED AND GENESIS HEALTHCARE FORM STRATEGIC COLLABORATION FOR POST-ACUTE CARE
- BETH ISRAEL, LAHEY HEALTH SIGNAL INTENT TO MERGE
- HMA TAPS AETNA EXECUTIVE AS NEW VP OF BUSINESS DEVELOPMENT

IN FOCUS

INDIANA SUBMITS HEALTH INDIANA PLAN 2.0 WAIVER RENEWAL REQUEST TO CMS

This week, our *In Focus* section comes to us from HMA Principal Sarah Jagger, of our Indianapolis, Indiana office. Sarah provides an overview of the Healthy Indiana Plan (HIP) and the proposed changes under the HIP 2.0 waiver renewal request, submitted to the Centers for Medicare & Medicaid Services (CMS) for approval on January 31, 2017.

History of HIP

The Healthy Indiana Plan (HIP) was passed by the 2007 Indiana General Assembly with bi-partisan support. Following the Centers for Medicare and Medicaid Services (CMS) approval, HIP began enrolling uninsured adults aged 19-64 under 200 percent of the federal poverty level (FPL) into coverage on January 1, 2008. *[Continued on Page 3]*

HEALTH MANAGEMENT ASSOCIATES

2017 HMA CONFERENCE SPONSORSHIP OPPORTUNITIES

+ The Future of Medicaid is Here:
Implications for Payers, Providers and States

SEPTEMBER
10-11th
2017

Chicago, IL
Projected Attendance 250

PRIMARY AUDIENCE:

- Medicaid managed care plans
- Hospitals, clinics and other providers
- Community-based organizations
- State and federal Medicaid regulators

Sponsorship Opportunities:

TABLETOP EXHIBIT:

$7,500

Includes two full conference registrations and logo on conference signs, website and materials.

For more information, contact
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Confirmed Keynote Speakers to Date
(in alphabetical order; others to be announced)

+ The Growing Role of Medicaid Managed Care

Laurie Brubaker
Head of Aetna Medicaid

J. Mario Molina, MD
President, CEO, Molina Healthcare

Pamela Morris
President, CEO, CareSource

Fran Soistman
EVP, Government Services, Aetna, Inc.

Paul Tufano
Chairman, CEO, AmeriHealth Caritas

+ The Future of State Innovation in Medicaid

Gary Jessee
Deputy Executive Commissioner, Medical and Social Services, Texas Health and Human Services

+ The Pros and Cons of Shared Responsibility in Medicaid

Joe Moser
Director of Medicaid, Indiana Family and Social Services Administration

History of HIP [Continued from Page 1]

The original HIP program had an enrollment cap in order to manage the program within the state's funding source (a percent of the state's cigarette tax revenue). Following the passage of the Affordable Care Act, the 2011 Indiana General Assembly voted to codify HIP as the state's vehicle for Medicaid expansion. In 2014, then Governor Mike Pence opted to seek expansion of Indiana's HIP program to cover individuals in the new adult group. Funding for this expansion was secured beyond the cigarette tax revenue through an agreement with Indiana hospitals leveraging the state's hospital assessment fee. In January 2015, CMS approved the HIP 2.0 program through a three year waiver expiring in January 2018.

On January 31, 2017, the state of Indiana submitted a waiver extension application to CMS to continue HIP for another three year period from February 1, 2018, to January 31, 2021.

In addition to the HIP 2.0 waiver modifications discussed in detail below, Indiana's waiver application includes requests related to substance use disorder (SUD) treatment services and waiver of the long-standing CMS exclusion of services provided to Medicaid eligible adults between 21 and 64 years of age in Institutions for Mental Disease (IMDs). This overview is solely focused on the proposed modifications to HIP 2.0 and does not summarize the SUD waiver requests made by the state.

The HIP 2.0 Waiver Model

The Healthy Indiana Plan (HIP) is a consumer-driven health plan for Medicaid beneficiaries. HIP offers low-income, non-disabled adults a high deductible health plan paired with a Personal Wellness and Responsibility (POWER) account, which is modeled on health savings accounts. The POWER account, valued at $2,500, contains contributions made by the State and the member. Member contributions equal two percent (2 percent) of income, but no less than $1.00 per month and no more than $100.00 per month. Contributions are intended to give participants "skin in the game" and incentivize individuals to become engaged in their healthcare and adopt healthy behaviors.

Consistent with commercial market practices, applicants are required to make their first month's POWER account contribution prior to the start of benefits. Benefits begin the first day of the month in which the contribution was received. In order to expedite coverage, applicants are provided the opportunity to pay a ten dollar ($10.00) fast track POWER account prepayment, while their eligibility application is being processed. This prepayment accelerates enrollment into the program.

HIP offers members three benefit packages – HIP Plus, HIP Basic, and HIP Employer Link. The HIP Plus plan includes enhanced benefits, vision and dental, to create an incentive for members to make regular monthly contributions to their POWER account. The only other cost-sharing for HIP Plus members are copayments for non-emergency use of hospital emergency departments (ED). The first non-emergent use of the ED requires an $8.00 copayment with a $25.00 copayment for each subsequent non-emergent ED visit. Members at or below the FPL are transferred to HIP Basic if they do not make their POWER account contributions. When HIP members over 100 percent FPL fail to make their monthly POWER account contribution for two consecutive months, they are

terminated from HIP, consistent with commercial market policies. These members cannot reenroll for six months. Individuals determined medically frail[1] do not lose benefits due to non-payment of POWER account contributions. In addition to not covering the enhanced benefits available through HIP Plus, the HIP Basic plan applies copayments to all healthcare services.

Every HIP member is provided a POWER account regardless of their benefit plan. The POWER account contributions create a direct financial investment for members in their healthcare and is designed to incentivize members to manage their accounts and utilize free preventive services. The first $2,500 in annual health care expenses are covered by the POWER account, additional expenses are fully covered by the state at no additional cost to the member. HIP members own their POWER account contributions and are entitled to a portion of unused contributions when they leave the program. Members who obtain preventive services are eligible to reduce their future POWER account contributions.

Individuals enrolled in HIP Employer Link receive the benefits provided through their employer sponsored health insurance (ESI) through the provision of a $4,000 HIP Link POWER account. The account reimburses enrollees for the costs associated with the ESI plan, including premium costs that are in excess of the required monthly POWER account contribution and other out of pocket cost sharing.

Further innovations that promote consumerism and personal responsibility that implemented in the first year of HIP 2.0 include the rollout of debit cards that allow members to make payments to providers directly from their POWER account at the point of service. In addition, members also have the ability to pay POWER account contributions to all the managed care entities at no additional charge at Wal-Mart locations.

Requested HIP Program Modifications

The HIP program has been successful in achieving its goal of reducing the number of uninsured, low income Hoosiers. Indiana reports that 60 percent of members who enrolled in HIP 2.0 were previously uninsured. As of December 1, 2016 HIP enrollment was over 394,000 individuals which exceeds the state's projected enrollment of 391,886 in the first year. The state's waiver renewal seeks to continue the current HIP model and incorporate the following program modifications that will further promote personal responsibility in a fiscally responsible manner:

- Expand incentives program
- Require tobacco-user premium surcharge
- Add new HIP Plus incentive
- Reestablish an open enrollment period
- Facilitate enrollment in HIP Maternity coverage for pregnant women
- Technical revisions and updates to 2015 Special Terms and Conditions

Healthy Incentive Initiative. To increase HIP member participation in Medicaid managed care incentive programs that primarily target preventive care and chronic disease management, the state will align member incentives with specific health challenges facing HIP members. These include: tobacco cessation, substance use disorder treatment, chronic disease management, and employment related incentives. The program will be designed to offer outcomes-based

[1] Individuals with certain physical, mental and behavioral health conditions.

incentives to members who meet individually achievable relative goals, as well as some process and participation measures. To more closely align with the private sector, the state seeks to significantly increase available incentives to a maximum of $200 per initiative, with a total of no more than $300 per member per year. The state's managed care contracts and provider incentives will be revised to align with the member health focus areas.

Tobacco-User Premium Surcharge. To improve tobacco cessation service utilization, Indiana Medicaid recently enhanced its benefit package removing restrictive reimbursement requirements for these services. To build upon those efforts, the waiver renewal seeks to increase member utilization of tobacco cessation services by, among other things, discouraging tobacco use through a premium surcharge for HIP Plus members. Similarly, the private market leverages higher premiums on tobacco users. Under this surcharge in HIP, POWER account contributions will increase for tobacco users in accordance with the allowable Affordable Care Act rating rules which allow qualified health plans to charge up to 1.5 times the non-smoker rate. Members who are known tobacco users will be required to pay monthly contributions equal to three percent (3 percent) of income in their second year of eligibility. The surcharge will be waived for the first year of enrollment to allow individuals the opportunity to take advantage of tobacco cessation benefits offered through HIP.

HIP Plus Incentive. The state seeks to add chiropractic benefits (one (1) visit per day and six visits per covered person per benefit year) to the HIP Plus plan. The intent being that this additional benefit will enhance the value proposition of making timely POWER account contributions and participating in HIP Plus.

Reestablish HIP Open Enrollment (Six Month Waiting Period). The original HIP program included a 12-month open enrollment period or lock-out period. Under this policy, HIP members who failed to comply with the redetermination process were not permitted to re-enroll in HIP for 12-months. In 2016, the Indiana General Assembly lowered the open enrollment period to six (6) months. Under the waiver renewal, the state seeks to require members who lose eligibility due to failure to comply with the redetermination process to wait six (6) months until they are permitted to re-enroll in HIP coverage. This policy would not apply to members who are medically frail, pregnant, low-income parents and caretakers, or low-income 19 and 20 year old dependents. Individuals who experience one of the legislated "change in circumstances"[2] and were prevented from competing the redetermination process would be exempt from the waiting period and permitted to re-enroll at any time.

HIP Maternity Coverage. HIP members who become pregnant may choose to remain enrolled in HIP, or may transfer to the Hoosier Healthwise program.[3] Women who choose to remain in HIP are required to transfer from HIP to Hoosier Healthwise if they remain pregnant during their annual redetermination period. HIP maternity coverage is equal to the coverage provided under Hoosier Healthwise as required by federal law. Finally, women who are pregnant at the time of Medicaid application are enrolled in Hoosier Healthwise and then transitioned to HIP following the post-partum coverage period. To alleviate the administrative burden created by these required program transfers, the waiver

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[2] 405 Ind. Admin. Code 10-10-13(e) (2016).

[3] Indiana's traditional Medicaid managed care program for children and pregnant women.

renewal seeks to modify eligibility criteria to require enrollment in HIP for pregnant women with income under 138 percent FPL.

In addition to the above policy changes, the state seeks the following technical revisions and updates to the STCs:

- *Prior Claims Payment Program*. The prior claims payment program provides retroactive coverage for medical services received during the 90-day period prior to the new member's HIP enrollment. The current STCs require this program for Section 1931 parents and caretakers who have not received Medicaid coverage within two (2) years of enrollment and who did not gain HIP coverage through presumptive eligibility. The waiver renewal requests that CMS remove the prior claims payment program for the waiver extension period citing low utilization as the reason for no longer requiring it.

- *Copayments for Non-Emergent Use of Hospital Emergency Department*. As previously noted, the HIP waiver includes graduated copayments for non-emergent use of the ED. The waiver renewal seeks to renew the cost sharing waiver beyond the initial two-year waiver period.

- *Non-Emergency Medical Transportation (NEMT)*. Indiana has operated HIP with a NEMT waiver for a number of years. HIP 2.0 granted a one-year waiver of this policy to evaluate it. The state reports that the initial evaluation found that state-provided NEMT benefits do not lead to improve member access to healthcare services for HIP members. As such, the state renews its request for a waiver of NEMT for the HIP waiver extension period. This request would not waive NEMT for the HIP populations[4] that are exempt from the alternative benefit plan and receive Medicaid State Plan services.

- *Hepatitis C Drug Coverage*. The waiver renewal seeks to incorporate the state's policy, which was made effective September 1, 2016, carving all covered hepatitis C drugs out of managed care.

- *Plan Changes and Member Transitions*. At the time of application, HIP members select a managed care entity (MCE) and can change their selection any time prior to making their initial POWER account contribution. HIP members thereafter may change their health plan annually during redetermination or anytime during the benefit period "for cause." Despite limited availability for transitioning between plans, the state indicates that members often leave and return to the program within a 12-month period. When this transition occurs, often the member changes health plans and therefore must be provided a new POWER account. To minimize these disruptions, the state seeks to have member plan choice locked in for a 12-month period; with the exception of "just cause" transitions. Member POWER accounts would also be reinstated rather than receiving a new account. Finally, the state proposes to immediately enroll members moving into HIP from another Medicaid category or between HIP coverage types into the HIP Basic plan and allowing a 60-day window to make the initial POWER account contribution and move to HIP Plus.

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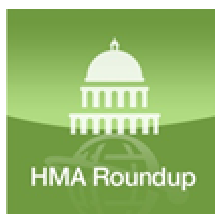
[4] Pregnant women, individuals determined to be medically frail, Section 1931 parents and caretaker relatives, and individuals eligible for transitional medical assistance.

Requested Expansion of HIP Employer Link

HIP Employer Link allows HIP eligible individuals who have access to qualifying ESI to enroll in the employer's health insurance instead of HIP through premium assistance. HIP Employer Link is not available to members eligible for other Medicaid programs in Indiana. For example, children under age 19 are not eligible for HIP Employer Link premium assistance. The state seeks authority to extend the HIP Employer Link coverage option to all Medicaid eligible family members (excluding those individuals with limited benefit packages or Medicare dual eligibles) of HIP Employer Link enrollees provided the family coverage is affordable. The current HIP Link program does not exclude high deductible health plans provided the plan passes the HIP Link affordability assessment. The waiver renewal requests that this same policy be extended when assessing coverage for family members of HIP Link enrollees.

Link to HIP 2.0 Section 1115 Waiver Extension Application

http://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf



HMA Medicaid Roundup

Alabama

Medicaid Director Calls for More Funding Ahead of RCO Implementation. *AL.com* reported on January 30, 2017, that Alabama Medicaid Commissioner Stephanie Azar is calling for additional funds to help support the state's planned rollout of Medicaid regional care organizations (RCO) beginning October 1, 2017. Azar is asking for another $44 million in fiscal year 2018 on top of the one-time boost of $105 million the program will receive from the state's oil spill settlement with BP. Lawmakers are expecting a budget deficit of up to $165 million in fiscal year 2019. Other cost increases for the agency include inflationary increases for nursing homes, pharmacy, and Medicare Part B costs. Azar is in discussions with the legislature's budget committees in advance of the session that begins February 7. Read More

California

Governor Vows to Protect Coverage Advances in the Event of ACA Repeal. *California Healthline* reported on January 25, 2017, that California Governor Jerry Brown said in his State of the State address that he plans to protect the state's advances in health coverage under the Affordable Care Act (ACA). However, the Governor also stated that repeal of the ACA would significantly impact the state budget. Health care advocates and legislators spoke out in support of Governor Brown and his concerns not only about ACA repeal, but also regarding Congressional proposals to turn Medicaid into a block grant program. Read More

Kaiser Permanente Working to Comply with Medicaid Data Requirements. *Kaiser Health News* reported on January 26, 2017, that Kaiser Permanente is working to comply with requirements to turn over certain Medicaid data to the California Department of Health Care Services (DHCS), after being assessed a $2.5 million fine. DHCS stated the fine is for failure to submit data on out-of-network care that Medi-Cal patients received from November 2014 to September 2016 and data on all physician-administered drugs from March 2010 to March 2015. Kaiser Permanente was notified of the fine on January 13, 2017. Data submissions are used by DHCS in rate-setting, as well as to ensure adequate care, and to monitor use of taxpayer dollars. Read More

Connecticut

Home Care Agencies Claim New EVV System Causing Payment Delays. *CT Mirror* reported on January 30, 2017, that Connecticut home care agencies are requesting a delay in further rollout of the state's new Medicaid electronic visit verification (EVV) system, which is meant to track when home care workers arrive at an individual's home and what services are provided. Agencies claim the system is causing payment delays. The Department of Social Services says there is no plan to delay the rollout, adding that the new system could save Medicaid between $8 million and $15 million a year as well as prevent over-billing. Agencies that provide personal care services began using the system January 1 of this year, while home health care agencies will be required to begin February 1. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Proposed Governor's Budget for Fiscal Year 2017-18. On January 31, 2017, Florida Governor Rick Scott unveiled a nearly $83.5 billion budget for 2017-18, just over 1 percent above the current $82.3 billion budget. The proposed General Revenue budget is $30.8 billion. The Governor's "Fighting for Florida's Future" recommended budget cuts taxes by $618 million, sets aside $5 billion in state reserves, boost education funding and cuts spending on hospitals. Below are highlights of the Medicaid budget.

Additions

- ***Medicaid Enrollment*** – Provides $626.4 million to fully fund Medicaid price level and estimated enrollment of 4.2 million.
- ***KidCare Enrollment*** – Provides $85.1 million to fully fund KidCare estimated enrollment of 211,656.
- ***Low Income Pool*** – Provides $607.8 million in continuation of LIP funding but with new measures for charitable purpose and profitmaking purposes, and new tier thresholds benchmarked to the for-profit sector. The program pays hospitals based on their charity care only, as measured by their Medicare rate. Hospitals are ranked from high to low based on their percentage of charity care to total margin. Hospitals are then divided into four tiers based on the level of charity care to total margin and all hospitals are paid a prescribed percentage of their charity care.
- ***Disproportionate Share Hospital -*** Provides $311.9 million for the Medicaid DSH program. No changes were made to rural DSH, Mental Health DSH, and Tuberculosis DSH programs. A total of $1 million is to be paid to hospitals that meet federal minimum requirements under Section 1923(b) of the Social Security Act. The remaining regular DSH is reserved for hospitals that have Medicaid inpatient utilization rates of more than 18 percent and have residents in the Statewide Medicaid Residency Program. Following are the DSH payments by program: Minimum - $1 million; Regular - $226.0 million; Rural - $10.3 million; Mental Health - $72.2 million; and Tuberculosis - $2.4 million.
- ***Redistribution of DSH*** – Provides $85.2 million to redistribute federal DSH allotments and the associated state share to eligible providers with

additional uncompensated care costs identified through an audit for Fiscal Year 2010-2011 and Fiscal Year 2011-2012.

- ***Florida Medicaid Management Information System (FMMIS)*** – Provides $5.8 million for the Medicaid Enterprise Systems procurement project.
- ***Preadmission Screening and Resident Review (PASRR)*** – Provides $750,000 to contract with a vendor to implement and operate the federally required PASRR program.
- ***Transfer Waivers to SMMC Managed Care*** – transfers funds and beneficiaries from the Adult Cystic Fibrosis Waiver ($474,206); Traumatic Brain Injury/Spinal Cord Medicaid Waiver ($1,976,544); and the Project AIDS Care Waiver ($4,346,859) to MMA and LTC managed care programs.
- ***APD Medicaid Waiver Waiting List*** – Provides $7.5 million to enroll onto the Home and Community-Based Services Waiver an additional 682 developmentally disabled individuals from the waiver waitlist.
- ***APD Medicaid Waiver LPN Rate Increase*** – Provides $3.4 million to support a rate increase for nursing services provided by licensed practical nurses under the Home and Community-Based Services Waiver to match the current Medicaid State Plan nursing rates.

Reductions

- ***Hospital Rate Reduction*** – Reduces $297.7 million by eliminating the add-on payment amounts to individual hospital rates for hospitals whose unreimbursed Medicaid and charity care in 2015 represented less than 67.06 percent of its overall profit, before applying a 10 percent disregard, measured according to the hospital's level of Medicare payments relative to charges.
- ***Offset Hospital Rate Inflation*** – Reduces $50.5 million that eliminates the automatic 2 percent annual inflation rate for hospital inpatient and hospital outpatient services.

Managed Care Hospital Payments – Reduces $581.3 million by shifting the range at which Medicaid managed care plans are allowed to contract with hospitals from between 100 and 120 percent to 90 and 110 percent of the Medicaid fee-for-service rates. Managed care plans in Medicaid pay hospitals at higher rates compared to the rates in Medicaid fee-for-service.

Hospitals Challenge Changes to Outpatient Rate Setting Methodology. *Health News Florida* reported on January 26, 2017, that Florida hospitals are disputing the methodology by which the state's Agency for Health Care Administration (AHCA) sets rates for Medicaid outpatient services. Changes proposed last year to the rate setting methodology would result in a reduction in hospital outpatient rates. Many large hospital systems argued that the rates, publicized in July 2016, were significantly lower than prior years, adding that AHCA was overstepping its authority absent legislative action to reduce rates. The challenges to the rate reductions and rate-setting methodology that were posted on the state Division of Administrative Hearings website over the past week were consolidated into a single case that will be heard by Administrative Law Judge J. Lawrence Johnston. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

State Senator Files Legislation to Continue Hospital Assessment Program Until 2020. *AJC.com* reported on January 25, 2017, that Georgia State Senator Butch Miller (R-Gainesville) has filed legislation to extend the state's hospital assessment program for another three years to 2020. The program, which assesses hospitals based on a percentage of patient revenue, raises approximately $311 million annually and allows the state to draw an additional $600 million in federal matching funds for Medicaid. Governor Nathan Deal has been encouraging legislators to continue to the program, which was instituted in 2010 and renewed in 2013. Read More

Lawmaker to Propose Plan to Build Up to 100 FQHCs. *AJC.com* reported on January 30, 2017, that Georgia state Representative Geoff Duncan (R-Cumming) will propose a measure to create up to 100 federally qualified health centers (FQHCs) in an effort to address the state's rural hospital crisis. The measure, which could cost $25 million if all 100 FQHCs are opened, would also provide incentives to encourage state employees and their families to use the centers. Since 2001, at least eight rural hospitals in Georgia have closed and more than a dozen are reportedly at risk. Read More

Lawmakers Propose Legislation to Limit Unexpected Bills for Patients. *Georgia Health News* reported on January 26, 2017, that two Georgia state lawmakers have introduced separate legislation to prevent balanced billing of patients and call for greater transparency regarding in-network providers and procedure costs. Balance billing is when providers bill patients for costs not covered by insurance. It can lead to high, unexpected bills when a patient in an in-network hospital, for example, is treated by an out-of-network provider working in the hospital. State Senator Renee Unterman (R-Buford) has proposed creation of a database of reasonable charges for procedures and would require providers and insurers to work out any disputes. State Representative Richard Smith (R-Columbus), meanwhile, has proposed requiring any provider who is authorized to work at a hospital to be in-network. The Georgia Association of Health Plans says it is committed to working with the legislature to find an appropriate solution. Read More

Hawaii

Lawmakers Propose Bills to Integrate ACA Measures into State Law. *The New York Times* reported on January 31, 2017, that state legislators in Hawaii are proposing maintaining key elements of the Affordable Care Act (ACA) in the event of repeal. The bills seek to guarantee that health plans do not deny coverage based on pre-existing conditions, institute lifetime maximums for coverage, or limit benefits. The bills include a mandate that individuals purchase insurance to make sure healthier patients continue to sign up, including an income tax credit to help pay for premiums for individuals with lower incomes. Read More

Kansas

State Legislator Proposes Bill Allowing Medicaid to Pay for Community-based Rehabilitation Programs. *KCUR* reported on January 27, 2017, that Kansas state Representative Dan Hawkins (R-Wichita) has proposed a bill to allow Medicaid to pay for psychosocial rehabilitation programs known as clubhouses. Clubhouse programs supplement the medication and therapy patients with mental illnesses receive from community mental health centers. This can include developing work and relationship skills. Representative Hawkins, the chairman of the House Health and Human Services Committee, believes the bill will help more individuals with mental illnesses to find work. The bill sets up a three-year trial period for funding the programs. The state could then extend the payments or let them lapse. Currently, Kansas has only one licensed clubhouse called Breakthrough Club. Read More

Maine

Health Care Advocates Collect Signatures to Add Medicaid Expansion to Ballot. *The Oklahoman* reported on January 25, 2017, that advocacy group Mainers for Health Care is stating that it has raised enough signatures to add Medicaid expansion to Maine's November ballot. The signatures must be verified by the Maine Secretary of State. Maine Governor Paul LePage opposes expansion. A spokesperson for the Governor's office said the state expanded Medicaid a decade ago and has only recently paid off debt to hospitals for unpaid services totaling $500 million. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

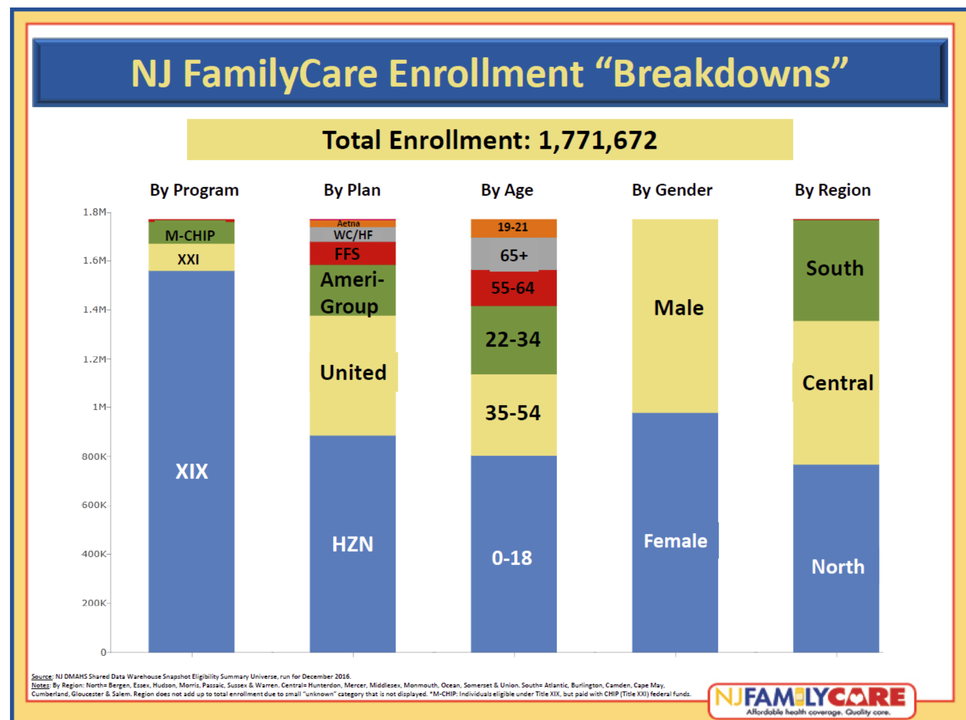
New Jersey Medicaid provides MAAC with an update on the Comprehensive 1115 Medicaid Waiver Renewal. On January 23, 2017, the Medical Assistance Advisory Council (MAAC) held a quarterly meeting and received an update from the Division of Medical Assistance and Health Services (DMAHS) Policy Director, Julie Cannariato on proposed revisions to the waiver renewal. Revisions were made in response to CMS comments on the initial renewal application. The revisions to the renewal application are posted to the DMAHS website and open for public comment until February 10, 2017. Details were added to the renewal application about the revisions for:

1. How DMAHS would finance the High-Fidelity Housing First (HFHF) model and a permanent supportive housing benefit;
2. How DMAHS would address behavioral health home services for the justice involved population;
3. Project ECHO as an example for how the state would implement telemedicine.

In addition, the state will continue with the existing managed long term services and supports (MLTSS) program and further drive quality and integration. They are soliciting comments on how to integrate behavioral health into a coordinated health delivery system beyond the five counties where they currently offer an integrated model of care. In response to comments received from stakeholders

the renewal application removed Medicare as a condition of Medicaid eligibility, and removed the Integrating Care Options for Dual Eligible Individuals concept, including both the seamless enrollment and integrated enrollment option. DMAHS will review the evaluations from Financial Alignment Initiative states on their passive enrollment experience to consider how to design and implement this under the D-SNP product. DMAHS is also working with CMS on how to transform its DSRIP program to a DSRIP 2.0 program.

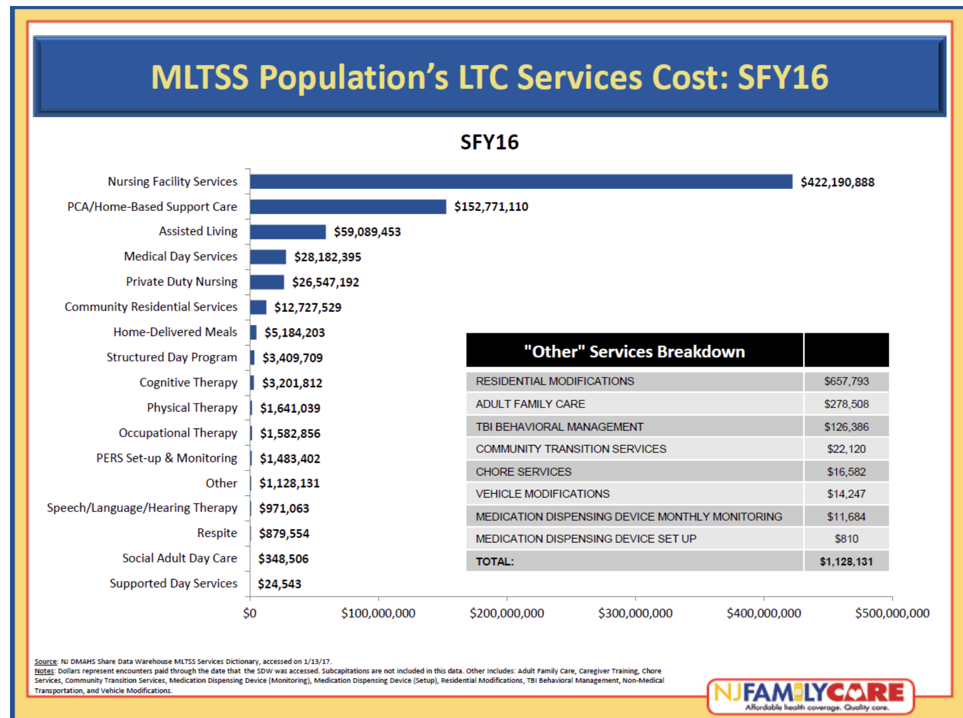
Medicaid Director Davey provides NJFamilyCare Update. At the January 23, 2017, MAAC meeting DMAHS Director Meghan Davey provided enrollment updates. The NJFamilyCare program, which includes individuals on Medicaid, Medicaid Expansion and CHIP is at the highest level in the program's history with 1,771,672 enrollees as of December 2016. This represents nearly 20 percent of New Jersey residents. Of these, 94.8 percent are enrolled in managed care and 46 percent are children. Total enrollment is further broken down in the following chart.



Medicaid managed care unified credentialing update. At the January 23, 2017 MAAC meeting Director Davey informed members that while DMAHS had hoped to go live sooner, the universal credentialing initiative will now be aligned with a larger replacement MMIS implementation scheduled for July 2018. This will eliminate the need to design two separate programs so that providers will only need to learn one process. The alignment will also enhance the agency's ability to monitor provider networks and improve the accuracy of provider data.

MLTSS update. At the January 23, 2017, MAAC meeting the Division of Aging Services Director, Nancy Day provided an update on the MLTSS implementation. The MLTSS program with 32,500 individuals, continues to rebalance and has seen a 13 percent increase in the number of individuals on MLTSS who live in the community. Nursing facilities (NF) have experienced a reduction by 1,000, which according to Director Day "just means it is more stable." There are 20,600 individuals receiving home and community based services. MLTSS enrollment

represents 1.8 percent of the overall NJFamilyCare population. Altogether, almost 50,000 people receive long term services and supports in the state including MLTSS, PACE and Medicaid fee-for-service. NF and Personal Care Attendant (PCA) services represent the largest group of long term care expenses under the program. Total MLTSS costs are provided:



In addition, the Any Willing Provider (AWP) policy whereby MCOs and nursing facilities must contract with one another and the MCOs must pay NFs at least at approved state Medicaid rates has been extended beyond its original two-year period until June 30, 2017. Before eliminating AWP, DMAHS will develop updated NF provider network requirements and quality indicators to be used in the contracting process between providers and the MCOs effective July 2017. Seven NF quality indicators will be introduced in Year 1, as detailed on Slides 86 – 89 of the MAAC meeting slides found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment (DSRIP) Program Update. One of the requirements of New York's Delivery System Reform Incentive Payment (DSRIP) Program is the convening of a stakeholder panel to serve as advisors and reviewers of Performing Provider Systems status and project performance during the 5-year DSRIP duration. The Project Approval and Oversight Panel (PAOP) met recently as part of the Mid-Point Assessment. New York Medicaid Director Jason Helgerson provided a brief update on the DSRIP program. He noted that in the first two years of the program, the PPSs had earned over 99 percent of available funds, totaling over $1 billion. During the first two years funds were distributed based on PPSs achieving process measures; distribution based on achieving outcomes will begin in Year 3, which begins in April 2017. Of the $1 billion that has been awarded, just over 40 percent of the funds have been

distributed. A preponderance of funds that have flowed continue to remain with the PPSs and/or the hospital systems that operate them.

- PPS Project Management Office - 43 percent
- Hospitals - 29 percent
- Other - 12 percent
- Clinics - 7 percent
- Primary Care Providers - 4 percent
- Community Based Organizations - 3 percent
- Mental Health - 2 percent

Helgerson also noted that among the 6,000 primary care providers participating in the 25 PPS networks PCMH recognition has risen from 31 percent at the baseline to 40 percent at the end of 2016; 23 percent had achieved Level 3 recognition. All PCPs will have to achieve Level 3 recognition by March 2018. Read More

New York Withdraws Request for Medicaid Coverage for Prisoners. Politico reports that the Cuomo administration has withdrawn its waiver request to CMS to provide Medicaid coverage to certain prisoners. The waiver would have extended Medicaid coverage to prisoners who have severe behavioral and physical health problems 30 days before they are released. The intent of the waiver was to establish a coordinated continuum of care for those who have access to health coverage through their re-entry. Given the uncertainty of the federal environment and the future direction of the Medicaid program, NY has temporarily withdrawn its waiver request. Read More

Office for People with Developmental Disabilities People First Agenda. The New York Office for People with Developmental Disabilities issued its quarterly newsletter addressing the People First agenda. The Acting Commissioner outlined the agency's priorities for 2017. These include:

- Further development of enhanced person-centered care coordination, with the first Care Coordination Organizations starting up in late 2017 or early 2018;
- External review of self-direction to help us further simplify and streamline self-direction;
- Enhanced transparency and communication through enhancements to public dashboard and more frequent reporting;
- Continuing focus on ensuring needed housing supports for those living at home with their families and in other settings, as well as enhanced focus on caregiver support;
- Working with providers to focus on the direct support workforce to strengthen recruitment and retention; and
- Continuing to focus on provider rates to ensure appropriate levels of person-centered, community-based supports, including for those with high needs. Read More

Department of Health Approves Four Additional Children's Health Homes. The New York Department of Health announced the approval of four additional health homes serving children effective February 1, 2017:

- Children's Health Home of Western New York dba Oishei Healthy Kids (Formerly Kaleida Health-Women and Children's Hospital of Buffalo)
- Greater Rochester Health Home Network LLC
- Institute for Family Health
- Mount Sinai Health Home Serving Children

To see a complete list of approved Health Homes Designated to Serve Children as of January 30, 2017, as well as their county service areas see the Health Homes Serving Children website.

Ohio

HMA Roundup – Jim Downie (Email Jim)

Governor Kasich Unveils Proposed 2018-2019 Biennial Budget. On January 31, 2017 *The Ohio Office of Health Transformation* reported Governor Kasich has unveiled his Executive Budget. The budget proposes a number of Medicaid initiatives, including expanding managed long term services and supports (MLTSS). The initiatives and some highlighted items are:

- ***Coverage Works*** – Maintains the Medicaid Expansion. Read More
- ***Improve Care Coordination*** - Beginning July 1, 2018, new populations will be enrolled in Ohio's Medicaid managed care program including individuals receiving community and facility based long term services and supports, participants in the Medicaid Buy-in Program for workers with disabilities, individuals dually eligible for Medicaid and Medicare who are not participating in the My Care Ohio program, and eligible individuals receiving refugee medical assistance. Ohio Medicaid will implement a new Managed Medicaid Long-Term Services and Supports (MLTSS) program through a competitive procurement. The goal is to select at least three plans to participate.
- Apply for an 1115 waiver to implement premiums of $20 per month for childless, non-pregnant adults with incomes above 100 percent of poverty.
- Provide financial incentives for Medicaid health plans to improve population health outcomes for youth. Beginning January 1, 2019, Medicaid will reward health plans an amount up to 0.5 percent of their child-related capitation payments for achieving improved academic performance.
- Replace the Medicaid Managed Care Sales Tax with a broad-based per member/per month fee. Medicaid managed care plans will pay a fee ranging from $26 to $56 per member month and non-Medicaid managed care plans will pay a $1 to $2 per member month fee. Read More
- ***Prioritize Home and Community Based Services*** – Restructures and/or increases rates for certain home and community based services; provides supports for self-directed waiver services. For individuals with intellectual disabilities, assists in avoiding or leaving an institution and increases use of technology to support community living. Read More

- ***Rebuild Community Behavioral Health System Capacity*** – Continues Ohio's Behavioral Health System transformation and adds behavioral health to Ohio's SIM Grant episodes of care. Read More
- ***Reform Provider Payments*** - Reduces hospital reimbursement 2.2 percent in 2018 and 5.7 percent in 2019; reduces nursing facility spending $99 million (3.3 percent) in 2018 and $117 million (3.9 percent) in 2019; and adopts a single preferred drug list. Read More
- ***Improve Program Performance*** - Integrates all Medicaid eligibility, claims, and provider enrollment functions; manages non-emergency medical transportation through a broker; coordinates efforts to fight fraud, waste and abuse; and creates a new, mostly federally-funded lead abatement program. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf Announces Plan to Create Department of Health and Human Services. Governor Wolf announced his plan to create a Department of Health and Human Services (HHS) in his 2017-2018 budget. Under the plan, the Departments of Health, Aging, Human Services and Drug and Alcohol Programs would be rolled into one Department of Health and Human Services. According to the administration, the move will not result in any program cuts for Pennsylvanians and reduction in staffing will be minimal. This change is intended to eliminate duplication and red tape, while streamlining delivery of services to seniors, people with intellectual and physical disabilities and those battling addiction. The move is expected to save money, but it is unclear how much. The agencies have a combined budget of more than $12.2 billion, with the bulk of it going to Medicaid and other programs operated by the Department of Human Services. The new department will be led by one secretary as well as a Cabinet-level adviser focused on opioid and heroin issues. Governor Wolf said he worked with the four department heads for months to figure how to integrate the programs to better deliver services while eliminating duplication. Further details of any savings will be revealed when the governor delivers his budget proposal. Read More

Medical Assistance Advisory Committee Meeting Updates. The following are updates from the January 26, 2017, Pennsylvania Medical Assistance Advisory Committee meeting.

- ***HealthChoices Update*:** The Office of Medical Assistance Programs (OMAP) stated that several bid protests have been filed in the HealthChoices reprocurement. The Department of Human Services (DHS) is currently in a stay and not moving forward with either Readiness Review or contract negotiations with the selected bidders. The department said that the previously announced June 1, 2017 implementation date is highly likely, however, they cannot provide an updated timeline just yet.
- ***Community HealthChoices Update:*** Implementation of CHC in the first zone will be delayed until January 1, 2018, due to protests of the awards. Three bidders filed protest in Commonwealth Court and of those, two filed requests for the department to stay negotiations with selected

bidders. The court denied both of those requests and OLTL will be moving forward with contract negotiations and readiness review with the selected offerors (Pennsylvania Health and Wellness, UPMC for You, and AmeriHealth Caritas) in the next few weeks.

- ***Certified Community Behavioral Health Clinics (CCBHCs) Update:*** It was recently announced that Pennsylvania was selected by CMS to conduct a two-year demonstration of CCBHCs. Dr. Dale Adair, Acting Medical Director for OMHSAS, said there will be ten clinics throughout Pennsylvania and the plan is to implement the CCBHCs by July 1, 2017. Currently dental care is not integrated in the clinics and Dr. Adair was urged by the committee to reconsider that policy.

Texas

Senate Finance Committee Hears Advocate Concerns Over Medicaid Therapy Cuts. *The Texas Tribune* reported on January 31, 2017, that parents and advocates urged Texas state Senate Finance Committee members at a hearing on January 31, 2017, against making further rate cuts to Medicaid speech, physical, and occupational therapy for children. The hearing came as the state is working to finalize the 2018-19 budget for the Texas Health and Human Services department. Texas implemented a $350 million rate cut in December 2016, which coincides with continued cuts to the state's Early Childhood Prevention program for children under three years old. Read More

Wisconsin

Governor, Medicaid Director Considering Medicaid Premiums, Eligibility Requirements. *Wisconsin State Journal* reported on January 29, 2017, that Wisconsin Governor Scott Walker may include Medicaid premiums, copays, and additional eligibility requirements in his proposed fiscal 2017-19 state budget. Wisconsin Medicaid director Michael Heifetz said the state is going to seek federal approval to charge premiums of $1 to $5 per month for childless adults, limit their coverage to four years, and require health assessments and drug testing. The state has also considered eliminating optional Medicaid benefits such as adult dental care and vision services. Governor Walker has spoken in favor of Medicaid block grants. Read More

National

CMS Offers to Extend Dual Demos in Massachusetts, Minnesota, and Washington. The Centers for Medicare & Medicaid Services (CMS) announced on January 19, 2017, that it hopes to work with state officials to extend dual eligible demonstration projects in Massachusetts, Minnesota, and Washington for two years through 2020. The three demos, which began in 2013, have shown positive results, but need additional time to be properly evaluated, according to CMS. CMS added that an extension would minimize the risk of beneficiary disruption and support clearer decision-making in state budgeting. The three states will need to submit a letter of intent by March 1, 2017, if they are interested in extending the demonstration. Read More

Growth in Medicaid Spending Could Overshadow Other Federal Programs, HHS Report Says. *Modern Healthcare* reported on January 30, 2017, that growth in Medicaid expenditures and enrollment could impact funding for other federal programs, according to the U.S. Department of Health & Human Services (HHS). State and federal Medicaid expenditures grew 4.3 percent to $575.9 billion in 2016, according to HHS' final Medicaid spending report under President Barack Obama's administration. Medicaid expenditures are expected to grow 5.7 percent annually through 2025. HHS says that the increases could displace spending for other federal programs or require additional taxes. The report comes as Republican lawmakers look for ways to control Medicaid spending through funding changes like block grants. The House Energy and Commerce Committee will host a hearing this week on the issue. Read More

MACPAC Addresses Challenges for States Under Block Grants or Per Capita Caps. *Roll Call* reported on January 24, 2017, that the Medicaid and CHIP Payment and Access Commission (MACPAC) is working to inform lawmakers and policy officials about the decisions required if the federal government decides to shift Medicaid funding to block grants or per capita funding caps. MACPAC estimates that by fiscal year 2024, state and federal spending for Medicaid is expected to reach $890 billion annually. Recent U.S. House budget proposals say that the federal government could save between $700 billion and $1 trillion by 2024 by changing Medicaid's funding structure, and that a capped federal funding approach would slow Medicaid cost growth. However, MACPAC vice chair Marsha Gold says that it is unlikely that states will be able to cut costs without impacting individuals covered by Medicaid. Read More

Health Care Industry Supports President's "One-In, Two-Out" Executive Order. *Modern Healthcare* reported on January 30, 2017, that health care industry stakeholders have voiced support for an executive order issued by President Donald Trump, with requires federal agencies to eliminate at least two regulations for every new one issued. Rick Pollack, CEO of the American Hospital Association, said. "The regulatory burden that is imposed on hospitals and health systems is substantial and unsustainable, and has grown in recent years. We are encouraged by the executive order signed by President Trump today that will help reduce red tape." Scott Whitaker, CEO of the Advanced Medical Technology Association, noted, "We look forward to working with the administration on developing regulatory policy that promotes medical innovation, patient access and maintains robust safety and effectiveness standards while minimizing unnecessary burdens on medical technology innovators." Read More

INDUSTRY NEWS

Kindred and Genesis HealthCare Form Strategic Collaboration for Post-Acute Care. Kindred Healthcare and Genesis HealthCare announced on January 31, 2017, a strategic clinical collaboration, bringing together two of the largest post-acute care providers in the country. While Genesis provides skilled nursing facilities, Kindred brings rehabilitation and post-acute services including home health, hospice, long-term acute care hospitals, and inpatient rehabilitation hospitals to the partnership. The two companies will collaborate to develop post-acute care networks, improve outcomes for specific populations, track population health data, and work on discharge planning and care transitions.

Hospital Systems Beth Israel, Lahey Health Signal Intent to Merge. *The Boston Globe* reported on January 30, 2017, that two Massachusetts health systems – Beth Israel Deaconess Medical Center and Lahey Health – have signed a letter of intent to pursue a merger. The two systems have been in talks regarding a possible merger for at least six years. Under the agreement, Beth Israel Deaconess Chief Executive Kevin Tabb would become CEO of the combined system, while Lahey Health Chief Executive Howard Grant would step down once the deal is completed. The merger is subject to regulatory approval. Read More

Investor-Owned Hospital Systems Focus on Reducing M&A Debt. *Modern Healthcare* reported on January 28, 2017, that large investor-owned hospital systems are focusing on reducing debt after a decade of significant merger and acquisition (M&A) activity. Companies are either laying low or actively reducing the number of facilities they own. Community Health Systems (CHS), which has a $15 billion debt, agreed to sell eight hospitals last year and is currently negotiating to sell an additional nine. Not-for-profit Curae Health and not-for-profit MultiCare are buying some of these to expand scale and geographic reach as reimbursement shifts from fee-for-service to value-based payments. Read More

COMPANY ANNOUNCEMENTS

- **"MCG Health Announces New Website"** Read More
- **"Three Finalists Named for the 2017 $100,000 Hearst Health Prize in Partnership with the Jefferson College of Population Health"** 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

HMA Taps Aetna Executive as New Vice President of Business Development

HMA announced on January 30, 2017, that Donna Checkett, current Aetna vice president for Medicaid growth, will join the firm as vice president of business development on February 6, 2017. Checkett will lead new business strategy for HMA.

"Change - fast-paced and unprecedented change - in healthcare is the new norm," said HMA CEO Marilynn Evert. "Donna knows the industry, the people and the programs inside and out. She has the executive leadership experience in both the public and private sectors and the strategic mindset to help our clients navigate the shifting market and continue to drive client and company growth."

For the last 19 years, Checkett has guided Medicaid market development and state government affairs for Aetna, a diversified healthcare benefits company serving more than 46 million consumers nationwide. She was CEO for Missouri Care, a Medicaid managed care plan owned by the University of Missouri and eventually acquired by Aetna. She also served eight years as Missouri Medicaid director, shaping early healthcare reform policy, leading the design and implementation of the state's first Medicaid managed care program, and championing large-scale revenue maximization solutions.

"The changes ahead in politics and in policy are a challenge and an opportunity for our clients and for HMA," said Checkett. "Our consultants are among the most experienced and forward-thinking professionals in the healthcare industry. They are hardwired for change, solution focused, and ready to seize the opportunities. My job is to chart the course."

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.

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.

http://healthmanagement.com/about-us/

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