

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... October 25, 2017



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THIS WEEK

- **IN FOCUS: HMA/KFF 50-STATE MEDICAID DIRECTOR SURVEY**
- 1332 WAIVER UPDATE: OREGON APPROVED, MASSACHUSETTS REJECTED, IOWA WITHDRAWN
- NEW JERSEY PROVIDES UPDATES ON FAMILYCARE PROGRAM
- KANSAS MEDICAID DIRECTOR STEPS DOWN
- FOUR MORE PLANS TO EXIT NEW YORK FIDA PROGRAM
- MARYLAND HOSPITAL COST COMPARISON WEBSITE LAUNCHED
- OKLAHOMA TO CUT MEDICAID PROVIDER RATES
- WISCONSIN TO INCREASE BEHAVIORAL HEALTH PROVIDER RATES
- IRS TO ENFORCE INDIVIDUAL HEALTH INSURANCE MANDATE DESPITE EXECUTIVE ORDER
- FEDERAL JUDGE ALLOWS ADMINISTRATION TO HALT CSR PAYMENTS
- CALIFORNIA SPENDS MOST ON INMATE HEALTH CARE, LOUISIANA SPENDS LEAST, REPORT FINDS
- TENET CEO STEPS DOWN MONTHS AHEAD OF PLANNED RESIGNATION
- CONVEY HEALTH SOLUTIONS ACQUIRES GORMAN HEALTH GROUP
- HMA AUTHORS BLOG POST FOR SOLVING DISPARITIES

IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the 17th annual Medicaid Budget Survey conducted by Health Management Associates for the Kaiser Family Foundation (KFF). Survey

results were released on October 19, 2017, in three new reports: *“Medicaid Enrollment & Spending Growth: FY 2017 & 2018,”* *“Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018,”* and *“Putting Medicaid in the Larger Budget Context: An In-Depth Look at Three States in FY 2017 and 2018.”* The reports were prepared by Kathleen Gifford, Eileen Ellis, Barbara Coulter Edwards, and Aimee Lashbrook from HMA, and by Elizabeth Hinton, Larisa Antonisse, Allison Valentine, and Robin Rudowitz from the Kaiser Family Foundation. HMA’s Dennis Roberts also contributed. The survey was conducted in collaboration with the National Association of Medicaid Directors.

This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2017 and FY 2018, highlighting policy changes implemented in state Medicaid programs in FY 2017 and those planned for implementation in FY 2018 based on information provided by the nation’s state Medicaid Directors.

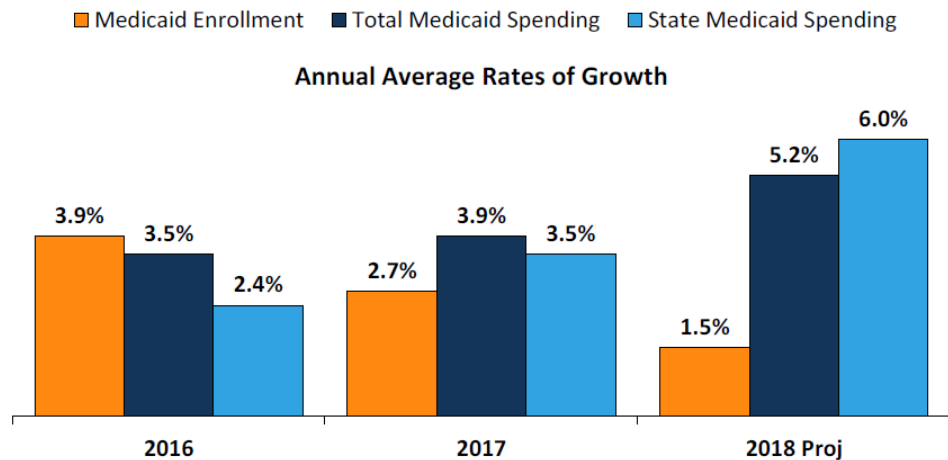
Key Report Highlights

In the following sections, we highlight a few of the major findings from the reports. This is a fraction of what is covered in the 50-state survey reports, which include significant detail and findings on policy changes and initiatives related to eligibility and enrollment, managed care, long-term services and supports (LTSS), provider payment rates, and covered benefits (including prescription drug policies). The reports also look at the key issues and challenges now facing Medicaid programs.

Medicaid Enrollment and Spending Growth

After significant increases in FY 2015 associated with the implementation of the ACA Medicaid expansion, last year’s survey anticipated a slowdown in Medicaid spending and enrollment growth, which was confirmed by this year’s report. Medicaid enrollment growth slowed to 2.7 percent nationally in FY 2017, down from 3.9 percent in FY 2016. Total spending growth was 3.9 percent, up slightly from 3.5 percent the previous year. State Medicaid spending experienced an uptick from 2.4 percent in FY 2016 to 3.5 percent in FY 2017, as states that implemented the Medicaid expansion started to pay 5 percent of the costs of those enrollees in January 2017 (mid-way through the state fiscal year).

Figure 1 - Medicaid Enrollment and Spending Growth, FY 2016-2017 and FY 2018 (Projected)



SOURCE: Enrollment growth for FY 2016-2017 is based on KCMU analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports, accessed September 2017. The spending growth rate for FY 2016 is derived from KCMU Analysis of CMS Form 64 Data. All other growth rates are from the KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2017.

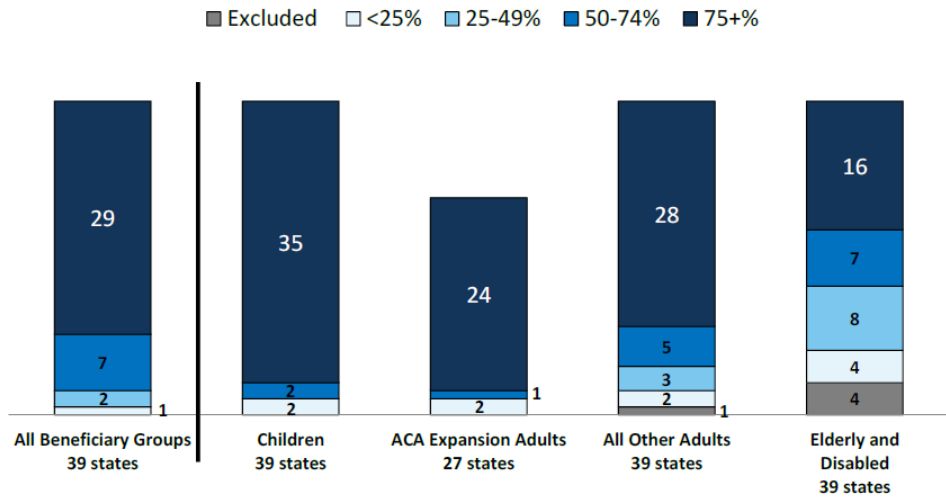
Medicaid Eligibility Standard Changes

- As of October 2017, 32 states have implemented the expansion (Louisiana was the latest state to adopt the expansion in FY 2017). Only a few states adopted other Medicaid eligibility expansions for FYs 2017 or 2018, and these changes were generally narrow in scope and targeted to a limited number of beneficiaries. The majority of states have policies in place to provide Medicaid coverage of inpatient care for those incarcerated in prisons or jails, to facilitate enrollment in Medicaid upon release, and to suspend, rather than terminate, Medicaid eligibility for incarcerated individuals.
- For FY 2018, several states are seeking Medicaid eligibility restrictions through Section 1115 waivers that apply to ACA Medicaid expansion and/or traditional Medicaid populations, including the addition of work requirements, elimination of retroactive eligibility, and elimination of Medicaid expansion coverage for those with income above 100 percent of the federal poverty level (FPL).

Medicaid Managed Care Policy Changes

- A total of 39 states (including DC) contract with risk-based managed care organizations (MCOs) to serve their Medicaid enrollees. As of July 2017, 29 states reported that 75 percent or more of their Medicaid beneficiaries were enrolled in MCOs.
- Because of nearly full MCO saturation in most MCO states, only a few states reported actions to increase MCO enrollment. Although many states still carve-out behavioral health services from MCO contracts, movement to carve-in these services continues.

Figure 2 – MCO Penetration Rates for Select Groups of Medicaid Beneficiaries, as of July 1, 2017



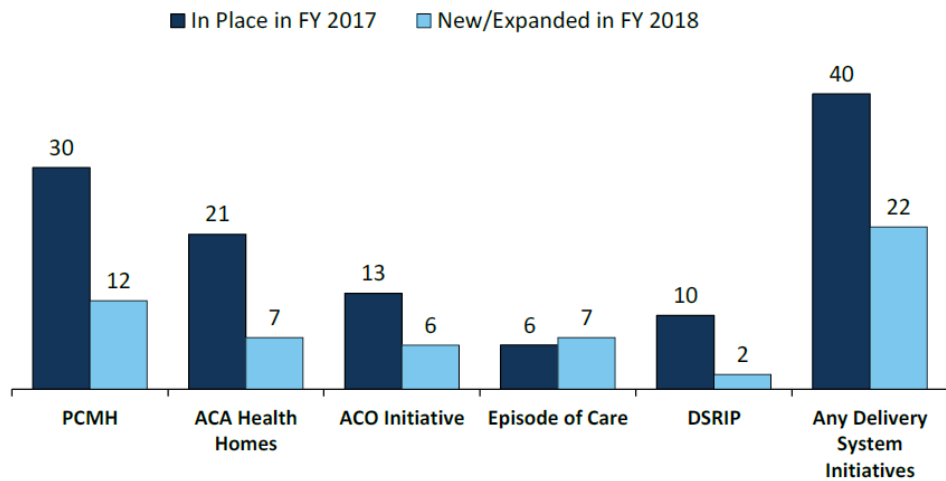
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

- Twenty-six of the 39 MCO states reported that they plan to use authority to receive federal matching funds for adults receiving inpatient psychiatric or substance use disorder (SUD) treatment in an institution for mental disease (IMD) for no more than 15 days a month included in the 2016 managed care regulations.
- States are using MCO arrangements to increase attention to the social determinants of health and to promote value-based payment. States are increasingly requiring MCOs to screen beneficiaries for social needs (19 states in FY 2017 and 2 additional states in FY 2018); to provide care coordination pre-release to incarcerated individuals (6 states in FY 2017 and 1 additional state in FY 2018); and to use alternative payment models (APMs) to reimburse providers (13 states in FY 2017 set a target percentage of MCO provider payments that must be in an APM and 9 additional states plan to set targets in FY 201).

Emerging Delivery System and Payment Reform Initiatives

- Forty states have one or more delivery system or payment reform initiatives in place in FY 2017 (e.g., patient-centered medical home (PCMH), ACA Health Home, accountable care organization (ACO), episode of care payment, or delivery system reform incentive program (DSRIP)).
- Six states reported episode of care initiatives in place in FY 2017 (up from only two states in FY 2015). For FY 2018, four of these states reported expanding these initiatives and three states reported new episode of care initiatives. Although states continue to show interest in DSRIP initiatives (that emerged under the Obama administration), the future of DSRIP remains unclear under the new administration

Figure 3 - Number of States with Delivery System Reform Activity, FYs 2017-2018

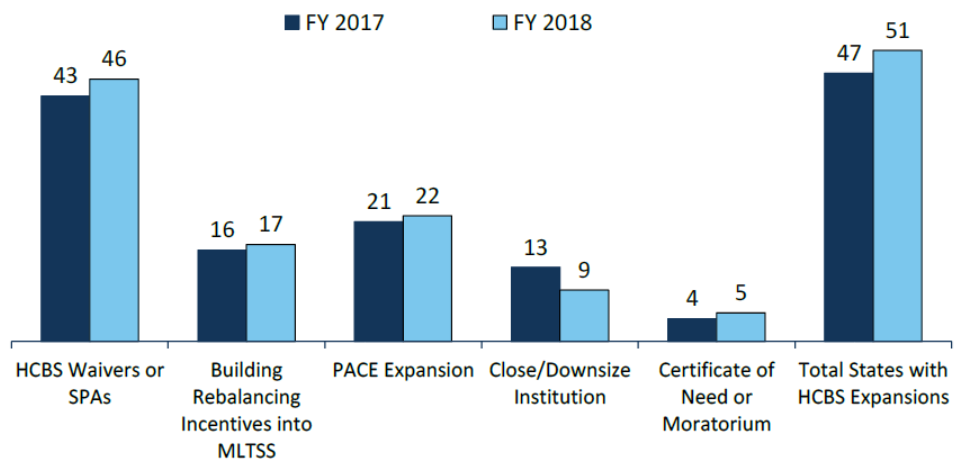


SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

Long Term Services and Supports (LTSS)

- Nearly every state reported actions to expand the number of persons served in community settings in both years (46 states in FY 2016 and 47 states in FY 2017).

Figure 4 - State Long-Term Care Actions to Serve More Individuals in Community Settings, FYs 2017-2018



SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

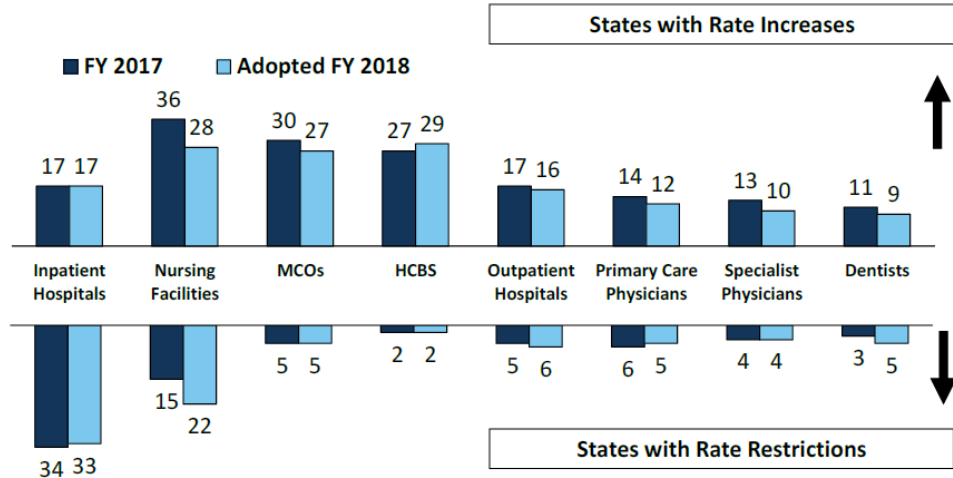
- Housing supports are an increasingly important part of state LTSS benefits. Over half of states (27) reported that they implemented or expanded housing-related activities in FY 2017 or FY 2018 (up from 16 states reported last year).

Provider Rates and Taxes

- About half of MCO states (18 of 39) require MCO rates to follow FFS rate changes for some provider types and two states (Louisiana and Mississippi) require MCO rates to be tied to FFS for all providers. Twenty-four states reported they had MCO rate floors for some

provider types, and five states reported they had minimum MCO payment requirements for all types of Medicaid providers.

Figure 5 – Provider Rate Changes Implemented in FY 2017 and Adopted for FY 2018



SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

- Federal legislation recently under consideration in the Senate proposed to phase down the limit on state use of provider taxes (the “safe harbor threshold”) from the current allowable level, 6.0 percent of net patient revenues, to 5.0 percent of net patient revenues by FY 2025 in one proposal and 4.0 percent by FY 2025 in another. In this year’s budget survey, 29 states reported having at least one provider tax exceeding 5.5 percent of net patient revenues and 46 states reported having at least one provider tax exceeding 3.5 percent as of July 1, 2017. The data suggests that these federal proposals would restrict states’ ability to supply the non-federal share to finance Medicaid and could therefore shift additional costs to states.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top priorities, issues, and challenges for FY 2018 and beyond, Medicaid directors listed the following:

- Federal legislative proposals around the ACA Medicaid expansion and proposed federal Medicaid financing reforms;
- Section 1115 Medicaid demonstration waivers;
- Payment and delivery system reform initiatives;
- Substance use disorder treatment initiatives;
- Long term services and supports; and
- Medicaid infrastructure development.

Links to Kaiser/HMA 50-State Survey Reports

[Link to “Medicaid Enrollment & Spending Growth: FY 2017 & 2018”](#)

[Link to “Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018”](#)

[Link to “Putting Medicaid in the Larger Budget Context: An In-Depth Look at Three States in FY 2017 and FY 2018”](#)



HMA MEDICAID ROUNDUP

Arkansas

State to Conduct Comprehensive Assessment of Health Care Landscape. Arkansas announced on October 19, 2017, that it will conduct a comprehensive assessment of the state's overall health care coverage landscape, including issuing recommendations by March 2018 on how the state Legislature can improve the market. The Arkansas Department of Human Services, Insurance Department, and Department of Workforce Services will analyze coverage issues impacting the uninsured, Medicaid, commercial insurance, and government health care programs. Health Management Associates and Leavitt Partners, LLC will assist with the assessment.

Florida

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

State May Seek Federal Funds to Maintain KidCare Coverage to Hurricane Victims. The *Miami Herald* reported on October 20, 2017, that Florida may now submit a waiver requesting approximately \$6.2 million in federal KidCare funding to maintain coverage for more than 4,000 families affected by Hurricane Irma. KidCare, which is a Florida Healthy Kids program, provides subsidized health care coverage to children in families at 133 percent to 200 percent of the federal poverty level. Families impacted by Hurricane Irma have struggled to pay their share of premiums and face a lapse in coverage. [Read More](#)

Georgia

Republican Lawmaker Pushes for Medicaid Expansion. *WABE* reported on October 20, 2017, that Georgia Senator Renee Unterman (R-Buford), who is chair of the state Senate Committee on Health and Human Services, will push for Medicaid expansion during the state's next legislative session. Senator Unterman said that the additional federal funding that comes with expansion could help struggling rural hospitals, six of which had to close over the past few years. [Read More](#)

Idaho

Health Advocates Seek to Expand Medicaid Through Ballot Initiative. *U.S. News* reported on October 23, 2017, that health care advocates in Idaho are seeking a ballot initiative in November to allow voters to decide whether to

expand Medicaid. The initiative requires at least 48,000 signatures before it can appear on the November ballot. [Read More](#)

Illinois

Exchange Plans Attached Surcharge to Premiums Ahead of CSR Executive Order. *Modern Healthcare* reported on October 18, 2017, that the Illinois Department of Insurance directed Exchange insurers to attach a surcharge to Silver plan premiums over the summer in expectation of the end of federal cost-sharing reduction (CSR) payment subsidies. While this maneuver provides stability for insurers in light of President Trump's executive order to end the CSR payments, it also means that consumers who purchase plans that do not qualify for CSR payments are facing higher premiums for 2018. [Read More](#)

Iowa

State Withdraws 1332 Waiver Request to Exit ACA Exchange Coverage. *The New York Times* reported on October 23, 2017, that Iowa has withdrawn a request for federal approval to exit the Affordable Care Act insurance Exchange and instead offer a single, state-run health plan with low premiums and a high deductible. Governor Kim Reynolds pulled the Section 1332 waiver request after the Trump administration indicated that the plan would likely increase the federal deficit and violate the terms of the ACA. [Read More](#)

Kansas

Medicaid Director Steps Down in Midst of Efforts to Extend KanCare. *U.S. News* reported on October 21, 2017, that Kansas Medicaid director Mike Randol will be stepping down as the state is about to submit a waiver request to extend its statewide Medicaid managed care program beyond next year. KanCare, the state's Medicaid program, will postpone the release of its plan until Friday. The state is also preparing to issue an RFP to rebid existing KanCare managed care contracts next month. [Read More](#)

Louisiana

Medicaid Managed Care Contracts Renewal Decision Delayed. *The Times-Picayune* reported on October 20, 2017, that the Louisiana Joint Legislative Committee on the Budget has delayed a decision on whether or not to extend the state's current Medicaid managed care contracts for two years. A special meeting to vote on the contracts will be held in one week. An extension is expected to be approved, but lawmakers may suggest a shorter duration than the proposed 23-months. [Read More](#)

Audit Report Addresses Medicaid Plan Behavioral Health Networks. *The News & Observer* reported on October 23, 2017, that Louisiana is failing to adequately monitor the behavioral provider networks of Medicaid managed care plans to ensure members have adequate access to mental health and drug addiction services, according to a report from the Louisiana Legislative Auditor. The report found that 45 percent of mental health professionals in

Medicaid plan networks did not meet licensing requirements. The report called on the state Department of Health to “strengthen its monitoring activities.” [Read More](#)

Maryland

Hospital Cost Comparison Website Launched. *The Baltimore Sun* reported on October 19, 2017, that Maryland has launched a website, <http://wearthecost.org/>, to help consumers compare hospital rates for hysterectomies, vaginal deliveries, hip replacements, and knee replacements. Information is based on claims data from health insurance plans for 2014-15 and includes the cost of surgery, doctor visits, physical therapy, and complications such as infections; not included is claims data from Medicare, Medicaid, or people who pay out of pocket. The Maryland Health Care Commission hopes to include pricing data for other procedures over time. [Read More](#)

Massachusetts

1332 Innovation Waiver Rejected by CMS. *The Washington Examiner* reported on October 23, 2017, that federal regulators rejected a Massachusetts 1332 Innovation Waiver, which would have allowed the state to establish a Premium Stabilization Fund to replace Exchange cost-sharing subsidies cut off by the Trump administration. The Centers for Medicare & Medicaid Services (CMS) said that the waiver was not filed 180 days in advance of the proposed implementation date as required. [Read More](#)

Michigan

Medicaid Expansion Adds ‘Healthy Behavior’ Requirement for Estimated 20,000 Members. *Crain’s Detroit Business* reported on October 22, 2017, that under the Michigan Medicaid expansion waiver, an estimated 20,000 individuals in the Healthy Michigan program (or 3 percent of the entire expansion population) are at risk of losing coverage in April 2018 if they do not adopt a “healthy behavior,” such as participating in a smoking cessation program. A certification by a primary care doctor must be submitted to ensure coverage continues. The Michigan Department of Health and Human Services will begin outreach efforts before the April deadline and will encourage individuals who do lose coverage to purchase a plan through the Exchange. [Read More](#)

New Jersey

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

New Jersey Division of Mental Health and Addiction Services (DMHAS) reorganization update. On October 19, 2017 the Medical Assistance Advisory Council (MAAC) received an update from Valerie Mielke, Assistant Commissioner about the reorganization of the Division in its migration from the Department of Human Services (DHS) to the Department of Health (DOH). The reorganization includes a move of the licensing and investigative unit for the psychiatric hospitals. Ms. Mielke began by explaining that the driver for

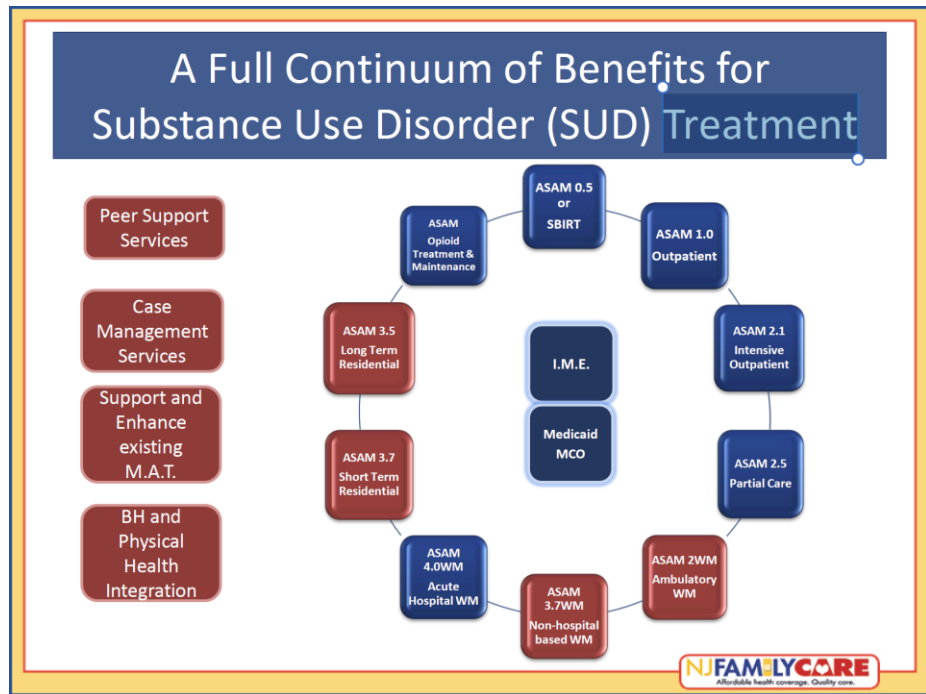
the changes is to better integrate physical and behavioral health services. Providers faced challenges previously, and had to comply with three sets of regulations to treat an individual with behavioral health needs.

The Division is in the middle of the 100-day transition and all staff have moved under DOH. Subcommittees comprised of leaders from DOH, DHS and DMHAS have formed to integrate legal (regulations) and fiscal (provider contracts) functions. DMHAS is conducting meetings in all 21 counties to discuss the transition and obtain feedback from stakeholders to inform the process.

NJ FamilyCare Comprehensive Demonstration update. On October 19, 2017, the MAAC received an update on the NJ FamilyCare Comprehensive Demonstration and Community Care Program (the 1115 waiver renewal) from Julie Cannariato, Policy Director of the Division of Medical Assistance and Health Services (DMAHS). CMS approved the Comprehensive Demonstration on July 27, 2017, effective August 1, 2017 through June 30, 2022. It will:

- **Maintain MLTSS and expand its monitoring activities** for: 1) enrollment information, 2) LTSS/HCBS costs, 3) grievances and appeals, 4) LTSS utilization, 5) FFS to MLTSS transition continuity of care, 6) quality assurance/monitoring quality metrics, and 7) access monitoring and additional monitoring (see Standard Terms and Conditions (STC) #66 in the [waiver document](#))
- **Increase access to services and supports for individuals with intellectual and developmental disabilities (I/DD)**
 - Moved the authority for the Community Care Waiver (CCW) under the Comprehensive Waiver. This does *not* move the CCW services into managed care.
 - Terminates the CCW 1915(c) waiver, which will now operate under the 1115 waiver
- **Expand access and services to children under the home and community-based programs**
 - Two pilot programs under the original 1115 waiver will be converted to the Children's Support Services Program (CSSP), a new feature of the waiver. These include: 1) Children with I/DD with Co-occurring Mental Illness pilot, and 2) Serious Emotional Disturbance (SED) program. These pilot programs are for the I/DD population under the age of 21.
 - Individuals who are not eligible for Medicaid or CHIP with I/DD, with income up to 300 percent of the Federal Benefit Rate receive state plan services and targeted HCBS services.
- **Continue DSRIP funding**
 - DSRIP will continue for the first three (3) years of the waiver renewal with \$166,000,000
 - New Jersey plans to transition DSRIP to an alternative payment mechanism by June 30, 2020 to replace supplemental payments.

- **Expand the continuum of substance use disorder (SUD) treatment.** SUD services identified in the red boxes in the following SUD benefits chart will be covered under the waiver renewal:



- **Reform of the Institutions for Mental Diseases (IMD) Exclusion.** New Jersey received approval to begin claiming expenditures for services provided in a residential facility that would otherwise be excluded as an IMD for individuals ages 18 and over (ASAM 3.7WM, ASAM 3.7 and ASAM 3.5). The state must maintain a combined average length of stay of 30 days or less for these services. The change in policy aims to improve clinical outcomes, increase access, prevent delays in treatment and promote sustained recovery.
- **Move the Autism Spectrum Disorder (ASD) Program under a state plan amendment.** The original 1115 waiver piloted ASD to provide NJ FamilyCare eligible children with needed therapies that they were unable to access under the state plan that were available to other children via private health insurance. Under the waiver children under 13 with ASD could access habilitation services. A state plan amendment will be filed with CMS to continue ongoing access to these services. See STC #38 in the [Comprehensive Waiver document](#) for additional information.

Additional initiatives that were raised during waiver renewal discussions will continue outside of the waiver and will address: the justice involved population, Medicaid housing and tenancy supports, increased access/evidence-based telehealth, and alternative payment methodologies.

NJ FamilyCare Aged, Blind and Disabled (ABD) Program update. On October 19, 2017, Heidi Smith, Chief Operating Officer of DMAHS provided the NJ MAAC with information about the revised ABD application and renewal process. The ABD application has been revised to delete contents that

were considered unnecessary to determine an applicant’s eligibility for Medicaid. In addition, an on-line version of the application is slated to go live in December 2017. The process was further streamlined to increase referrals to Area Agencies on Aging, allow self-attestation for individuals with income under 100 percent of the federal poverty level, and ensure reinstatement of MCO enrollment within 60 days. More online verifications will be used including Asset Verification System, Social Security Administration and HUB.

Child Core Set Measures update. On October 19, 2017 Cynthia Rogers, Director of the Office of Quality Assurance provided an update on New Jersey’s efforts of its voluntary reporting on Child Core Set Measures to CMS. The core set includes a range of children’s quality measures encompassing both physical and mental health that CMS released beginning January 2012. Updates to the measurement set occur annually. In 2015 New Jersey reported on 15 of the 24 core set measures, while in 2016 New Jersey reported on 18 of the 26 core set measures. In 2017 there will be 27 measures; New Jersey anticipates reporting on 18 of them. Ms. Rogers reported on New Jersey’s rate for those 2015 measures for Access, Well Child Visits, Immunizations and Prenatal Care for which it exceeded the median performance rates of all reporting states in most of the measures.

Median Performance Rates vs. NJ Rates FFY 2015 Access/Well Child Visits		
Measure	New Jersey Rate	Median Performance Rates
Access		
Access to Primary Care (12-24 months)	96.6%	95.2%
Access to Primary Care (25 months – 6 Years)	92.6%	88.0%
Access to Primary Care (7-11 Years)	94.6%	91.4%
Access to Primary Care (12-19 Years)	92.2%	92.2%
Well Child Visits		
Well Child Visits: First 15 Months	70.0%	60.1%
Well Child Visits: 3-6 Years	78.1%	66.9%
Adolescent Well Child Visits	63.7%	45.4%



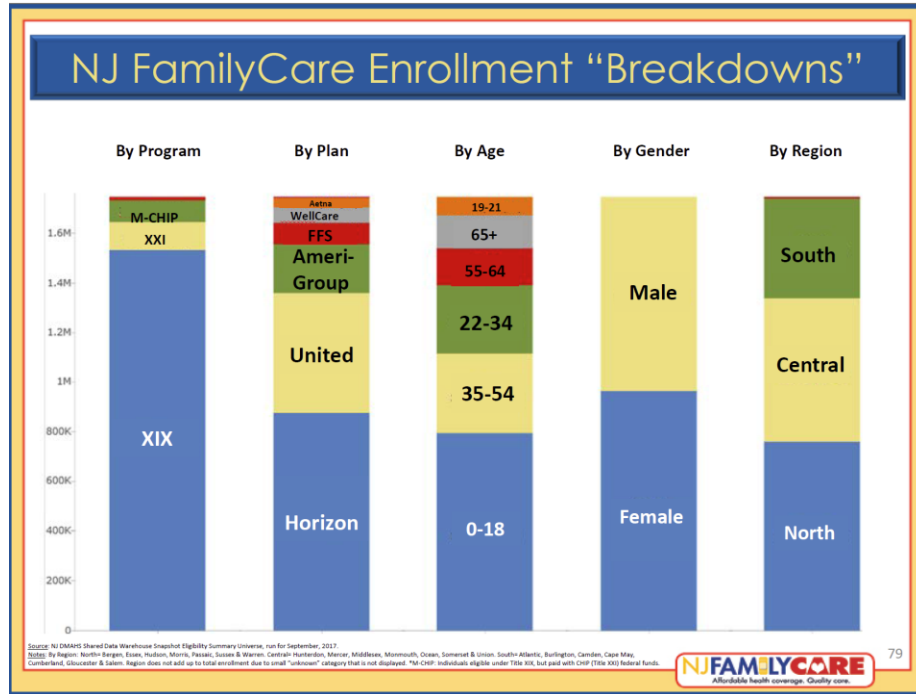
Median Performance Rates vs. NJ Rates
FFY 2015 Immunizations/Prenatal Care

Measure	New Jersey Rate	Median Performance Rates
Immunizations		
Childhood Immunization Status: Combo 3	65.2%	67.1%
Immunizations for Adolescents: Combo 1	85.7%	67.4%
Human Papillomavirus Vaccine	21.2%	20.8%
Prenatal Care		
Timeliness of Prenatal Care	85.4%	82.0%
Frequency of Ongoing Prenatal Care	61.2%	64.4%



Non-Emergency Medical Transportation update. At the October 19, 2017 MAAC meeting, Steven Tunney, DMAHS Chief of Behavioral Health and Customer Service provided the MAAC with an update on its transportation broker contract with LogistiCare. The state awarded LogistiCare a three-year contract beginning September 2017. They will provide transportation, insurance verification, driver training verification, background, driving records and drug tests, vehicle inspections and trip verification services. As of August 2017, LogistiCare arranged for over 600,000 trips or 19,400 trips per day. In the last year 99.5 percent of all trips had no complaint and the percentage of valid complaints have declined from .38 percent to .22 percent in the same period. Additional information can be found on slides 54-74 [here](#).

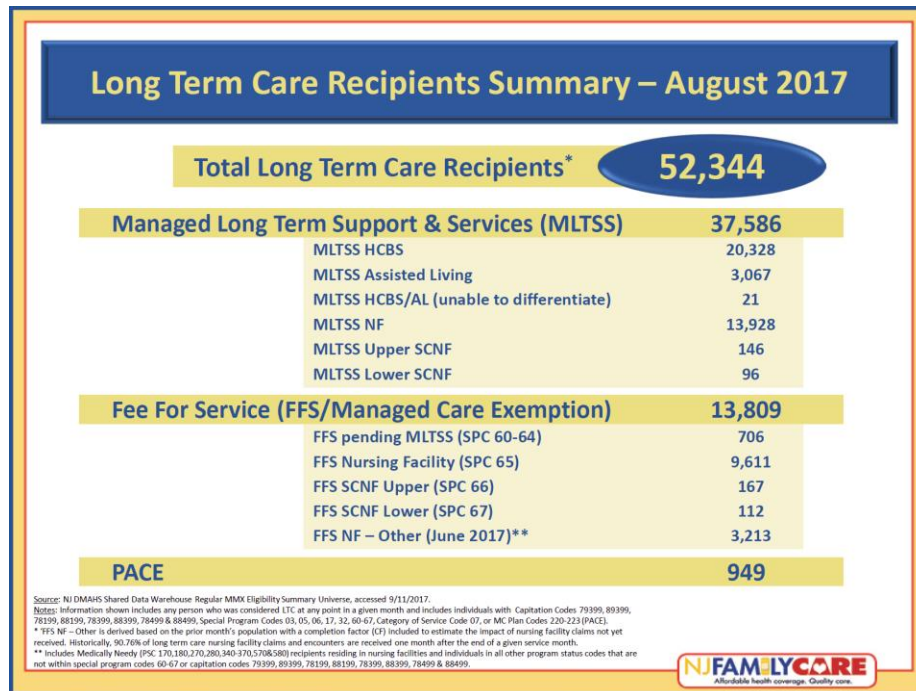
Medicaid Director Davey provides NJ FamilyCare Update. At the October 19, 2017 MAAC meeting, DMAHS Director, Meghan Davey, provided Medicaid program enrollment updates. The NJ FamilyCare program, which includes individuals on Medicaid, Medicaid Expansion and CHIP, has a total of 1,744,819 people enrolled as of September 2017. This accounts for approximately 19.5 percent of the New Jersey residents. Total enrollment is further broken down in the following chart.



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe

The Medicaid Expansion population is 543,019 or 31 percent of all enrollees.

MLTSS Update. At the October 19, 2017 MAAC meeting, Laura Otterbourg, Director, Division of Aging Services, provided an update on the MLTSS implementation. As of August 2017, there were 52,344 long term care recipients in New Jersey. Of those enrolled, 71.8 percent are in MLTSS, 26.4 percent in FFS, and 1.8 percent in PACE. Medicaid long term care is distributed across care settings as follows:



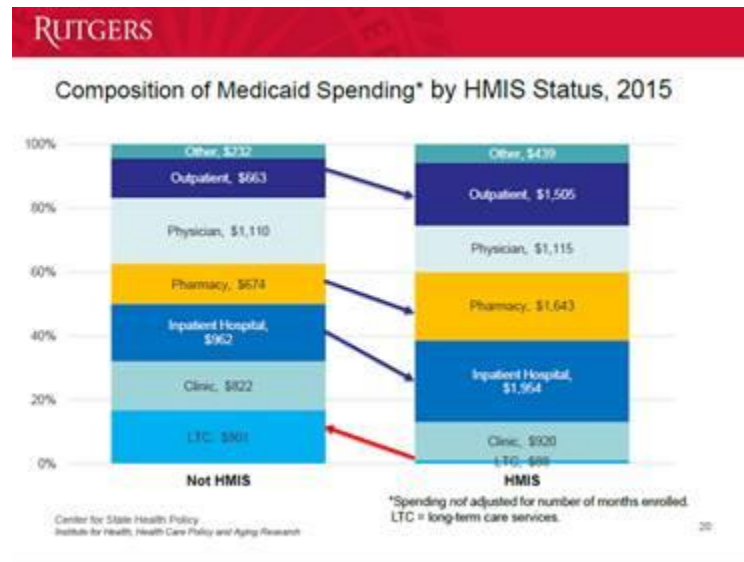
Last, a sixth PACE program, AtlantiCare LIFE Connection plans to open in Atlantic City in November 2017 and will serve individuals in Atlantic and Cape May counties. PACE expansions are planned for Beacon LIFE in Monmouth county, Lutheran Social Ministries in Union county and Life at Lourdes in southern Burlington county. The Division of Aging Services has identified a need for PACE in additional areas of the state with a high concentration of older adults and healthcare infrastructure to support PACE in Ocean, Essex, Bergen, Passaic and Middlesex counties. Letters of Intent for Ocean and Essex counties for interested PACE applicants in Ocean and Essex are due by December 18, 2017. Additional information about New Jersey's MLTSS update can be found on New Jersey MAAC slides 81 - 102 [here](#).

All presentations from the MAAC meeting can be found [here](#).

Study of homeless service use and Medicaid spending in New Jersey. Rutgers University, Center for State Health Policy, Institute for Health, Health Care Policy, and Aging Research offered preliminary findings on the Medicaid beneficiaries' spending experiences when they also are in the Homeless Management Information System. The analysis was made possible by linking 2011-2016 data from the Homeless Management Information System (HMIS) with the Medicaid Management Information System (MMIS) under a data sharing agreement. The study is supported by the Nicholson Foundation and the New Jersey Division of Medical Assistance and Health Services (DMAHS).

The researchers are studying the Medicaid spending experience of beneficiaries who use homeless services to identify opportunities to generate Medicaid savings and improve patient outcomes. They also want to estimate the impact on Medicaid spending of permanent supportive housing placement.

The percentage of Medicaid beneficiaries in HMIS grew from about 2.5 to 3.0 percent over the five years in the study (or 38,000 - 68,000 individuals). Medicaid beneficiaries with HMIS status are disproportionately adults ages 25-60 (56.2 percent), black (49 percent), with a mental health and/or substance use disorder (46.1 percent vs. 23.6 percent) with higher average hospital or emergency department utilization. The average annual Medicaid spend for individuals with HMIS status in 2015 was \$8,714 or over \$2,000 more than that of an individual without HMIS status. Medicaid spending by service categories for HMIS beneficiaries also exceeds that of their non-HMIS counterparts as illustrated in the following chart.



A presentation with complete study results can be found [here](#).

Medicaid Fraud Division issues audit report on Personal Preference Program. On October 18, 2017 the State Comptroller, Medicaid Fraud Division released an audit of Community Access Unlimited, Inc. (CAU, the former fiscal agent for participants in the Personal Preference Program (PPP). PPP allows individuals to direct and manage their own home and personal care services and is supervised by the Department of Human Services, Division of Disability Services (DDS). As fiscal agent, CAU acted as custodian of an PPP participant bank accounts used to pay for services by PPP providers from 1999 through March 2017.

The audit found CAU compliance issues and weaknesses in DDS' contract oversight of CAU. The report cites:

- CAU failed to return unspent Participant and administrative funds and interest earned to the state Medicaid program each year amounting to \$10.7 million
- A portion of the retained funds was transferred to the wife of CAU's executive director to invest on CAU's behalf
- CAU and DDS entered into multiple Memoranda of Understanding to the contract without the required state approvals.

A copy of the audit report can be found [here](#).

New York

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

Future of Integrated Care in New York to be Addressed in Upcoming Meeting. The Department of Health's Division of Long Term Care, together with the Centers of Medicare and Medicaid Services, will be convening the fourth meeting for the stakeholder series on the future of integrated care in New York State. These sessions are designed to facilitate the conversation on what they envision for the State's integrated care programs after 2019. Topics covered this session include: 1) Payment and Rate Considerations, 2) Outreach,

Education, and Engagement of Participants and Providers, 3) MCO/Plan Requirements and Qualifications, and 4) Enrollment. The meeting will take place Thursday, November 16th from 11:30am-2:00pm. Stakeholders are invited to either attend in person at One Commerce Plaza, room 1613, in Albany, or via webinar/conference call. To attend in person RSVP no later than November 14, 2017, with the first and last names of attendees to futureofintegratedcare@health.ny.gov. Participation in New York's duals demonstration program, Fully Integrated Duals Advantage (FIDA), remains disappointing. Four additional FIDA plans are withdrawing from the demonstration program as of January 2018. According to *Crain's HealthPulse*, Independence Care System, North Shore-LIJ Health Plan, Aetna and Fidelis Care will no longer participate in FIDA. GuildNet has indicated it will end operations in Nassau County but maintain coverage in New York City. Twenty-three plans were initially approved to operate a FIDA plan; 14 plans will remain in the program in 2018. A total of 4,566 dual-eligibles were enrolled in FIDA plans as of September 2017, although the state's initial estimate indicated that as many as 140,000 individuals were eligible. [Read More](#)

Delivery System Reform Incentive Payment Program Best Practices. The New York Department of Health has posted a new whiteboard video that highlights best practices currently happening among the Performing Provider Systems that are participating in New York's Delivery System Reform Incentive Payment (DSRIP) program. Some of the projects showcased include establishing an innovation fund, adopting best practices with data, addressing social determinants of health, adopting a regional approach to crisis intervention, and mobilizing around high priority community health needs. [Link to Video](#)

United Hospital Fund Report Highlights Patient-Centered Medical Homes in New York. A recent report from the United Hospital Fund indicates that New York State is tied with California for first in the nation in implementing the patient-centered medical home model, in which all or most of a patient's health care needs are coordinated through a primary care physician. However, growth in the number of providers offering medical homes is starting to slow in New York, and small independent primary care practices have been much slower to adopt the model. The report is an update on the progress made in implementing medical homes statewide over the past year. UHF has been monitoring adoption of medical homes in New York based on the National Committee for Quality Assurance model since 2011, and in its latest report identifies several trends:

- The number of patient-centered medical home providers in New York continues to expand, but over the past two years growth has slowed.
- Growth upstate and on Long Island now outpaces growth in New York City. This year the number of patient-centered medical home providers outside NYC is greater than the number in the city (3,856 vs. 2,935).
- Large and medium-size health care organizations have been the main drivers of patient-centered medical home growth; adoption among small independent primary care providers continues to be much slower.

[Read More](#)

Department of Health to Host Public Comment on Medicaid 1115 Waiver.

The Department of Health will be convening its annual public comment session for New York's section 1115 Medicaid waiver programs on November 16 from 1 - 4 pm. Feedback on all aspects of New York's Medicaid waiver programs is welcomed; comments can also be submitted in writing through November 19 to 1115waivers@health.ny.gov. In addition to staff from the Department of Health, members of the DSRIP Project Approval and Oversight Panel (PAOP) will attend the session. The PAOP is tasked with serving as advisors and reviewers of Performing Provider Systems status and project performance during the 5-year DSRIP program. The session will be held in the Reading Room of the NY Academy of Medicine, 1216 5th Ave, New York. Prior to the public comment session, the PAOP will be meeting to discuss three items: an update on the mid-point assessment, an overview of the independent evaluation, and the NY Prevention Agenda and DSRIP. The meetings are open to the public and will be webcast live; no pre-registration is required. [Read More](#)

Developmental Disability Assessment Tool Reviewed. The Office for People With Developmental Disabilities (OPWDD) has released a validity study evaluating the Coordinated Assessment System (CAS), an assessment instrument developed utilizing the interRAI Intellectual Disability (ID) instrument as its foundation and then creating needs-specific supplements. OPWDD wanted to test the instrument to assure its validity when applied to the population of people receiving services from OPWDD. OPWDD conducted an agency case study that solicited feedback from people assessed, their families and providers about the person-centered administration process utilized by the CAS. In addition, they conducted a formal validity study on the interRAI scales within the CAS instrument. The study included over 1,100 individuals, which allowed OPWDD to determine whether the interRAI scales within the CAS were sensitive enough to capture the range of needs of a person receiving services through OPWDD. The report outlines the evaluation process for the CAS instrument and the interRAI scales within the CAS, including the research hypotheses, methods and instruments used in the validity study, and analysis activities and results. [Read More](#)

Department of Health Announces Regulatory Modernization Initiative. The Department of Health has announced a comprehensive Regulatory Modernization Initiative to review a whole host of regulations governing licensure and oversight of health care facilities with the goal of streamlining and updating existing policies and regulations across a range of areas to best meet the needs of payers, providers, and consumers in the years ahead. 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 state has scheduled a meeting for the Long Term Care Need Methodologies and Innovative Models Workgroup on November 7 in Meeting Room 6, Empire State Plaza in Albany from 12:30 to 3:30. The workgroup will provide feedback to the Department on regulatory reforms to facilitate provision of innovative models of care to meet the needs of communities, including rural communities. Lora LeFebvre, past SUNY Associate Vice Chancellor for Health Affairs will be leading the discussion along with Mark Kissinger, Special Assistant to the Commissioner, NYS Department of Health. To attend the meeting, RSVP at

RegulatoryModernization@health.ny.gov. Written comments can also be submitted to that address. The meeting will also be webcast [here](#).

Oklahoma

State to Cut Medicaid Provider Rates by 9 Percent, LTC Facilities by 4 Percent to Fill Budget Gap. *The Oklahoman* reported on October 23, 2017, that in order to fill a \$215 million budget gap, \$70 million of which was intended for the Oklahoma Health Care Authority (OHCA), Oklahoma will cut Medicaid provider reimbursement rates by 9 percent and long-term care facility rates by 4 percent. It will also end care coordination payments to providers if a patient has not had a visit within the last two years and eliminate Medicaid payments for some out-of-pocket costs for patients who also are eligible for Medicare. OHCA may also restrict or cut other services, including breastfeeding education for pregnant women, nutritional consulting, genetic counseling, and short-term stays in care facilities for individuals with intellectual disabilities, pending board approval. Oklahoma had originally intended to use a cigarette tax to close the budget gap, but the proposal was struck down by the Oklahoma Supreme Court. [Read More](#)

Oregon

1332 Innovation Waiver Approved by CMS. *Fierce Healthcare* reported on October 19, 2017, that the Centers for Medicare & Medicaid Services (CMS) approved a Section 1332 waiver allowing Oregon to set up a reinsurance program partially funded through a state health insurance tax. The waiver, which is effective from 2018 through 2022, removes the Affordable Care Act's single-risk-pool requirement for the state. [Read More](#)

Pennsylvania

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

Pennsylvania Awards \$4 million in Grants for Medication-Assisted Treatment Programs. Four of Pennsylvania's biggest health systems each have received \$1 million state grants to build or expand medication-assisted treatment (MAT) programs. The recipients of the grants are Penn State Health, which is the parent of Penn State Hershey Medical Center, Geisinger, WellSpan Health, and Allegheny Health Network. The health systems are expected to use the grants to establish a "hub and spoke" approach where a centrally-located addiction specialist will support family doctors who want to prescribe medications to patients who are addicted. [Read More](#)

DHS Announces \$690 Million in Human Services' Recoveries and Cost Avoidance. Pennsylvania's Department of Human Services announced \$690 million in program integrity cost avoidance and recoveries in 2016-2017, \$328 million of which are savings in state dollars. This represents a 6.5 percent, or \$42 million, increase in savings from 2015-2016. Governor Tom Wolf's administration credits:

- Increased enrollment in the Health Insurance Premium Program (HIPP), thereby relieving some of the burden on HealthChoices.
- Streamlining Third- Party Liability (TPL) casualty and estate recoveries

- Increased use of data analytics to help to identify patterns of fraud, waste, and abuse

[Read More](#)

Texas

CHIP Funding Could Run Out in January 2018. *The Texas Tribune* reported on October 24, 2017, that funding for the Texas Children's Health Insurance Program (CHIP) could run out as early as January 2018, sooner than originally expected, according to a spokesperson for the Texas Health and Human Services Commission. A federal decision to waive co-pays and enrollment fees for CHIP recipients in the wake of Hurricane Harvey has cut into remaining funds. Texas has approximately 400,000 enrollees who would be affected. [Read More](#)

Wisconsin

Medicaid Behavioral Health Provider Rates to be Increased. *USA Today Network-Wisconsin* reported on October 24, 2017, that Wisconsin will increase mental health and substance abuse provider reimbursement rates in 2018. Advocates hope the move will allow behavioral health providers to increase access to services for Medicaid patients. Wisconsin Governor Scott Walker announced the move, which will utilize funds already approved for health care programs. Wisconsin has approximately 1 million Medicaid members, of whom 100,000 received outpatient mental health or substance abuse care last year. [Read More](#)

National

Federal Judge Denies Request to Immediately Reinstate CSR Payments. *Politico* reported on October 25, 2017, that U.S. District Court Judge Vince Chhabria ruled against an emergency order to force President Donald Trump's administration to continue making cost-sharing reduction (CSR) subsidy payments to Exchange insurers. Eighteen states and the District of Columbia filed a lawsuit against the Trump administration for halting the payments, citing that the administration violated a federal law by ending a legally mandated system currently in operation. [Read More](#)

MACPAC Meeting on CHIP, Opioid Use Disorders, CMMI Scheduled for October 26-27. The Medicaid and CHIP Payment and Access Commission (MACPAC) announced on October 23, 2017, that the next meeting of the commission will be held on October 26-27. Topics to be discussed are:

- Children's Health Insurance Program
- Opioid Use Disorders
- Streamlining Medicaid Managed Care Authorities
- CMS Medicaid Innovation Accelerator Program
- Payment Policy for Federally Qualified Health Centers
- Disproportionate Share Hospital Payments

- Future of Center for Medicare and Medicaid Innovation
- Managed Long-Term Services and Supports
- Multistate Collaboration

[Read More](#)

Insurance, Medical Device Industries Fight to Repeal ACA Taxes. *The Hill* reported on October 25, 2017, that the insurance and medical device industries are scrambling to build support for legislation aimed at delaying or eliminating taxes imposed by the Affordable Care Act (ACA). This week, 179 U.S. Representatives sent a letter to Speaker Paul Ryan (R-WI) calling for repeal of the medical device tax. Legislation in the House to repeal the tax has 260 co-sponsors, while a Senate measure has 14 co-sponsors. Insurers and medical device companies say the taxes will be harmful and could lead to higher premiums. Implementation of the taxes have been delayed since 2015. [Read More](#)

Senate, House Republicans Propose Alternative Bill to Stabilize ACA Exchanges. *Reuters* reported on October 24, 2017, that Senate Finance Committee Chairman, Senator Orrin Hatch (R-UT), and House Ways and Means Committee Chairman, Representative Kevin Brady (R-TX), have released a new [proposal](#) aimed at stabilizing the Affordable Care Act health insurance Exchanges. The Hatch-Brady bill would reinstate cost-sharing subsidies and repeal the individual and employer mandates. The initiative represents an alternative to bipartisan legislation proposed by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA). [Read More](#)

IRS to Enforce Individual Health Insurance Mandate Despite Executive Order. *The New York Times* reported on October 20, 2017, that the Internal Revenue Service will reject 2018 tax returns that do not include information about health care coverage, including whether a tax penalty is due for failing to obtain insurance. The announcement comes despite an executive order from President Trump, which aims to ease regulations associated with the Affordable Care Act. [Read More](#)

Industry Research

California Spends Most on Inmate Health Care, Louisiana Spends Least, Report Finds. The Pew Charitable Trusts reported on October 18, 2017, that median prison health care spending in the U.S. was \$5,720 per inmate in fiscal year 2015. California had the highest spending at \$19,796 per inmate, while Louisiana had the lowest at \$2,173. Total national spending was \$8.1 billion, representing approximately one-fifth of all prison costs. Thirty-five states reported that they operated a prison health care quality monitoring system in fiscal 2016. [Read More](#)



INDUSTRY NEWS

Tenet CEO Steps Down Months Ahead of Planned Resignation. *Modern Healthcare* reported on October 23, 2017, that Tenet Healthcare CEO Trevor Fetter has resigned from his position several months earlier than expected. Executive Chairman Ronald Rittenmeyer will serve as interim CEO while the company searches for a permanent replacement. Fetter had originally planned to step down in March or when a successor was appointed. Tenet is restructuring in an effort to cut costs and streamline operations. The company reported a \$56 million operating loss in the second quarter of 2017. [Read More](#)

Convey Health Solutions Acquires Gorman Health Group. Convey Health Solutions announced that it had acquired Washington, DC-based Gorman Health Group, which provides consulting services to companies and organizations involved in government-sponsored health care. Financial terms were not disclosed. Convey is a business process outsourcing company serving the Medicare Advantage and Medicare Part D markets. [Read More](#)

Centene Posts Increase in 3Q17 Membership, Net Income. *Modern Healthcare* reported on October 24, 2017, that Centene Corp. posted a 7.7 percent increase in membership to 12.3 million in the third quarter of 2017, compared to the same period last year. Revenues and net income also rose. [Read More](#)

Centene, Mercy Health of Arkansas Venture Approved to Serve Medicaid Special Needs Members. Centene Corp. announced on October 25, 2017, that the Arkansas Insurance Department issued a license to Arkansas Total Care to become a risk-based provider organization serving individuals with intellectual and developmental disabilities and those with high behavioral health needs. Arkansas Total Care is a joint venture between Mercy Health of Arkansas and Centene subsidiaries LifeShare and Arkansas Health & Wellness. [Read More](#)

Medica Health Plans Transfers \$120 Million to Other Operations. *StarTribune* reported on October 20, 2017, that Medica Health Plans transferred \$120 million in reserves from its not-for-profit Minnesota HMO to shore up other operations, including the company's for-profit businesses. Medica Insurance Co., which operates in Iowa, Nebraska, and Kansas, received \$90 million, while Medica Health Plans of Wisconsin received \$30 million. The move was criticized by Governor Mark Dayton and consumer advocates. [Read More](#)

Corizon Health Hit With Lawsuit Over Inmate Death. *The Kansas City Star* reported on October 17, 2017, that Corizon Health has been hit with a lawsuit in federal court by the family of an inmate who died at Hutchinson Correctional Facility in Kansas. Corizon is the nation's largest for-profit provider of prison health services, serving approximately 15 percent of the U.S. inmate population across 27 states. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
<i>Timeline to be Revised</i>	Alabama ICN (MLTSS)	RFP Release	25,000
October, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
<i>Timeline to be Revised</i>	Alabama ICN (MLTSS)	Proposals Due	25,000
November 1, 2017	Florida Statewide Medicaid Managed Care (SMMC)	Proposals Due	3,100,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 3, 2017	New Mexico	Proposals Due	700,000
November 17, 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
November, 2017	Kansas KanCare	RFP Release	380,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
<i>Timeline to be Revised</i>	Alabama ICN (MLTSS)	Implementation	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of state dual eligible financial alignment demonstration status.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	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	50,064	36.8%	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	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health (Centene); Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 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	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	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	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	10 States			1,254,200	391,440	31.2%	

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

HMA NEWS

HMA Experts Facilitate Diverse Focus Groups to Talk Health Care

HMA's Dr. Jean Glossa and Dr. Jeffrey Ring authored a post for the Solving Disparities blog around three focus groups held on consecutive evenings in the spring of 2017 as part of an important institutional self-reflection quality initiative undertaken by three clinics that make up Fairfax County's Community Health Care Network. This "root-cause analysis" process was part of a larger project funded by the Robert Wood Johnson Foundation's Finding Answers program, titled "Effects of Payment Incentives on Referral Processes in Multi-ethnic Network Serving the Uninsured." [Read More](#)

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