HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 29, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Jim Kumpel, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

IN FOCUS

CMS CLARIFIES HOSPITAL MEDICAID PRESUMPTIVE ELIGIBILITY POLICIES

This week, our *In Focus* section reviews the Centers for Medicare and Medicaid Services (CMS) informational bulleting and frequently asked questions (FAQ) document released on January 24, 2014, regarding the Affordable Care Act's requirement that all states implement hospital presumptive eligibility policies. Presumptive eligibility, often referred to as PE, allows certain qualified entities – such as hospitals, federally qualified health centers, and other providers – to make a preliminary eligibility determination for Medicaid or CHIP based on an individual's income and other information. Presumptive eligibility provides a mechanism by which hospitals and other providers can be reimbursed for services provided to individuals who are likely eligible for Medicaid, but not enrolled as of the date of service. In turn, this increases access to services and sets individuals on the path to coverage when a final eligibility determination for

Medicaid is made. Below we highlight some of the key takeaways from the CMS guidance documents, as well as review how the presumptive eligibility process will work and what states must do to implement.

Link to CMS Presumptive Eligibility FAQ

Presumptive Eligibility Structure and Reimbursement Takeaways

The CMS guidance documents provide detail on much of the structure and requirements of implementing presumptive eligibility, but also allows for some degree of state flexibility. Below are the key takeaway points about how presumptive eligibility will function and where states can modify the program to fit their needs. Also provided are details on federal matching rates under presumptive eligibility.

Timing, Duration, and Medicaid Application Requirements:

- Coverage begins on the date that the qualified hospital approves presumptive eligibility. The presumptive eligibility period continues until the end of the following month or until the individual is determined eligible for Medicaid. The Medicaid application must be completed by the last day of the following month.
- Completion of a Medicaid application is not a condition of presumptive eligibility. However, states may encourage or require hospitals to assist individuals in completing the Medicaid application process.

Eligibility and Benefits:

- Hospitals may use simplified estimations of income based on gross income or an approximation of modified adjusted gross income (MAGI) in determining presumptive eligibility. States must rely on attestation of information and may not require income verification as a condition of presumptive eligibility.
- States must require that presumptive eligibility be available to all MAGI-based Medicaid eligibility groups in that state, including pregnant women, children, newly-eligibles (if a state has expanded Medicaid), as well as covered individuals above 133 percent FPL, if the state has higher eligibility thresholds in place. States may optionally require presumptive eligibility for other eligibility groups, such as the aged, blind, and disabled population.
- Presumptive eligibility benefits may not be limited or reduced from the benefit package for the eligibility group for which the individual is presumed eligible.

Qualified Entities and Third-Party Administration:

- Earlier in January 2014, a *Health Affairs* brief on the presumptive eligibility issue indicated that many hospitals were concerned that CMS would not allow hospitals to turn over presumptive eligibility determinations to a third-party authority. CMS appears to have at least partially revisited this decision, as the January 24 FAQ document clearly states that hospitals may use a third party contractor to assist in presumptive eligibility determinations and full Medicaid applications, so long as the responsibility for the final determinations rests with the hospital.

Reimbursement and Federal Matching Rates:

- Completion of a Medicaid application is not a requirement for reimbursement under the presumptive eligibility period.

- Additionally, hospital services provided under the presumptive eligibility period will still be eligible for federal match even if the individual is determined not to be eligible for Medicaid. However, states may set standards for compliance and corrective action to ensure future compliance with presumptive eligibility requirements.
- Services provided under the presumptive eligibility period will be reimbursed at the prevailing federal medical assistance percentage (FMAP) in the state, and not at the newly eligible rate of 100 percent.
- States will have the option, however, to adjust claiming if the presumptive eligibility period falls under the three-month retroactive eligibility period for Medicaid, but retroactive adjustment is not required.

State Timing:

- Although the presumptive eligibility policy under the ACA took effect January 1, 2014, states have until March 31, 2014 to submit state plan amendment (SPA) filings to implement presumptive eligibility.

HMA Medicaid Roundup

Alaska

Alaska's Super Utilizers Pressuring Medicaid Program. The Alaska Dispatch published a January 27, 2014 article highlighting the pressure placed on both the state Medicaid program and local delivery systems by "super utilizers" who rely on emergency rooms to provide routine care. Medicaid Director Margaret Brodie told the Alaska House that one particular Anchorage neighborhood accounted for more than a third of the city's 3,000 super utilizers, in part, because the Alaska Regional Hospital is on a bus route in an area that lacks health clinics. The Division of Health Care Services (DHCS) hopes to guide many of these super utilizers to more appropriate, lower cost settings. Read more.

California

HMA Roundup—Alana Ketchel

CMS Delays CalOptima Participation in Dual Eligible Plan and Halts Enrollment in OneCare. On January 24, 2014, CMS officials announced that Cal MediConnect will not advance in Orange Country until CalOptima addresses concerns about the health plan's performance. The government performed a 10-day audit which revealed that "CalOptima failed to provide its enrollees with services and benefits in accordance to CMS requirements." Since CalOptima was the sole insurer in Orange County for the duals demonstration program, that county will not proceed with the demonstration until CalOptima "completes the corrective action." The health plan was also ordered to immediately stop enrolling Medicare beneficiaries in the 16,000-member OneCare program. The state had hoped to enroll up to 456,000 dual-eligible beneficiaries in the county into managed care under the demonstration. Read more.

Covered CA Rolls out Health Plan Quality Rating System. On January 28, 2014, Covered California announced it has added a quality rating system (QRS) to its website to help consumers select a health plan on the exchange. The QRS presents plan quality in a star rating with four stars being the highest score. Scores are based on members' experience with the plans, drawn from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The exchange stated that clinical performance scores will begin to include claims data and patient records in addition to member-reported experience starting in 2014. Read more.

Covered CA Gets Federal Dollars to Expand Outreach. On January 23, 2014, Covered California announced the receipt of $155 million in federal funding to expand outreach and marketing efforts. The marketing efforts will especially target young adults and uninsured Hispanics who are enrolling below the desired rates. Funds will also be used to enhance existing enrollment technology, to hire and train staff, and bolster the small-

group employer market. The exchange has faced recent criticism for customers' enrollment difficulties and the lack of Latino enrollees. Read more.

Covered CA Resolves Pediatric Dental Benefit Policy. At a meeting on January 23, 2014, the Covered California Board adopted a revised pediatric dental benefit policy for the individual market. In 2015, all health plans participating in the exchange will be required to offer pediatric dental coverage embedded with medical care as an essential health benefit. However, the embedded option will be offered alongside a stand-alone dental plan, allowing consumers to choose among models. Pediatric dental benefits are currently only offered as a side benefit and enrollment has been low; only 27 percent of the 34,000 children enrolled in Covered CA elected dental coverage. Read more.

Health Net Signs Dual Eligible Contract for LA and SD. On January 22, 2014, Health Net Community Solutions, Inc. announced that it had finalized a contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for the dual-eligible demonstration, Cal MediConnect, in Los Angeles and San Diego counties. The contract requires that Health Net provide managed care services for those eligible for both Medi-Cal and Medicare starting in April 2014. The goal of the demonstration is to lower the costs of care for dual-eligible beneficiaries while improving or maintaining the quality of their care. Read more.

Colorado

HMA Roundup—Joan Henneberry

Colorado Behavioral Health Information Exchange Receives Grant. On January 23, 2014, the Colorado Regional Health Information Organization (CORHIO) received a grant from Rose Community Foundation to improve behavioral health information exchange on its secure electronic network. The traditional separation of records among behavioral health care providers, primary care physicians, and hospitals has limited providers from gaining a complete health picture of behavioral health patients. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Summary of Governor Scott's Budget Recommendations. On January 29, 2014, Governor Rick Scott released his $74.19 billion budget proposal, which comes in just under the current year's budget. The "It's Your Money Tax Cut Budget" proposes paying down state debt by $170 million, keeping $5.1 billion in reserves, and returning $500 million to taxpayers through such measures as reduced motor vehicle license fees, lowering business taxes and filing fees, and sales tax holidays. Among the key healthcare proposals are the following:

- $403.7 million to adjust Medicaid workload, in line with the December 4, 2013 Social Services Estimating Conference (SSEC).
- $3.8 million for an adjustment to the Medicaid fiscal agent contract, in line with the December 4, 2013 Social Services Estimating Conference (SSEC).
- $20 million for the Developmentally Disabled Waiver to remove all 1,000 individuals with critical needs from the waiting list.
- $19.6 million for Long-Term Care waivers to address the needs of 1,280 individuals on the wait list.

- $4.1 million ($3.0m nonrecurring) from trust funds for supplemental legal representation associated with the Statewide Medicaid Managed Care (SMMC) program and a number of additional federal lawsuits.
- $200,000 in nonrecurring trust funds to contract with an independent evaluator to assess services, quality of services, and cost effectiveness of managed long term-care and home community-based services for elders and adults with disabilities.
- $5 million in nonrecurring trust funds for the services to identify fraud, waste and abuse in the Medicaid Program.
- $1 million in nonrecurring trust funds for a consultant to transition reimbursement from a cost-based system to a prospective payment system for nursing home services using Resource Utilization Groups (RUGs).
- $1 million in nonrecurring trust funds for a consultant to transition reimbursement from a cost-based system to a prospective payment system using Ambulatory Patient Groups (APGs) for hospital outpatient services.
- $30 million in increased funding to support cancer research and treatment.
- $1.3 million in nonrecurring funds to help seniors enroll in the Statewide Medicaid Managed Care (SMMC) Long Term Care program in the Department of Elder Affairs (DOEA).
- $4 million in additional funding to support the Alzheimer's Disease Initiative (ADI) program that will serve an estimated 392 frail individuals currently on the wait list (DOEA).
- $4 million in additional funding for the Community Care for the Elderly Program to deliver services to 601 frail individuals currently on the wait list.
- $1.6 million in start-up costs for two new Veterans nursing homes.

In addition, the budget contemplates $1 billion for the low income pool (LIP), contingent on waiver approval. The physician fee increase is only funded through calendar year end (December 2014).

Prestige Health Choice Medicaid Contract Still Up in the Air. On January 23, 2014, the Agency for Health Care Administration criticized the view of an administrative law judge that a company partly owned by Florida Blue—Prestige Health Choice—should not qualify for a Medicaid managed care contract for Monroe and Miami-Dade Counties. The recommendation, made by Judge John Van Laningham, called into question the viability of the company's eight regional contract awards, worth up to $2.3 billion in year one. However, the AHCA blasted the ruling for its "erroneous interpretation of the law" and noted that Prestige's Provider Service Network (PSN) contracts do qualify as a provider majority-owned entity. AHCA is expected to make a binding final determination by February 3, 2014. Read more.

Georgia

HMA Roundup – Mark Trail

DCH Board Adopts Cost-Share Approach to SHBP Design. On January 27, 2014, the DCH Board voted 5-0 to approve changes to the State Health Benefit Plan (SHBP) designs for 2014, which replace co-insurance with co-pays for medical and pharmacy

benefits. The $116 million cost of the changes will not be passed onto members, but will be drawn from SHBP reserves. The Board's decision creates the following changes:

- Re-institute a co-pay system as follows:
  - Three tier pharmacy co-pay: $20 for generics; $50 for preferred brands; and $80 for non-preferred
  - Office visit co-pay: $35 primary care, family practice, OBG, etc.; $45 for specialist care; $25 rehabilitation; $150 ER visit; and $35 urgent care
- The plan would use reserves to fund the change
- The change will be retroactively effective to the beginning of the plan year, January 1, 2014, though system change will not take place until March 14, 2014.

Previously, the Board had adopted a cost-sharing approach in August 2013, effective January 2014. However, Commissioner Clyde Reese III explained that many members in the plan didn't understand the full implication of that change, and many were experiencing hardship as a result. Blue Cross Blue Shield of Georgia (BCBSGA) will administer the revised SHBP plan designs. Read more.

Senior Advocates Anticipate Budgetary Pressures on Home-Based Funding. A January 25, 2014 article from the Macon Telegraph highlights concerns that Georgia's state budget promises little relief in chipping away at the waitlist of 11,000 seniors seeking home-based services. Vicki Johnson, legislative chair for the Georgia Council on Aging, claims that nearly 82 percent of people on the waitlist have conditions that should qualify for skilled home care, but are not poor enough to qualify for Medicaid. The council recommends that the state fund $6 million for home-based services and $4 million for Adult Protective Services to address that waitlist, but Governor Nathan Deal's draft budget would only fund $1 million for 11 APS positions and cash for emergency placements. In addition, while Georgia code authorizes DCH to issue licenses to adult day care facilities, no funding is available to pursue that process. Two bills are making their way through the legislature: one to create an Adult and Aging Services Agency to replace the Aging Division in the Department of Human Services and qualifying for its own budget; another bill would establish an Alzheimer's registry. These bills have moved through the Senate Health and Human Services Committee and await action by the Rules Committee. Read more.

Hawaii

Hawaii Health Connector Bills Seek State Control. On January 23, 2014, a package of legislation was introduced in the Hawaii state House of Representatives that would improve operations of the Hawaii Health Connector, including the shift of the nonprofit entity to state control. Following a December 2013 hearing critiquing the state's health exchange, legislators crafted five House bills to increase transparency and accountability of the organization, while seeking long-term sustainability.

- HB 2525 would require health plans to apply community rating in establishing premiums
- HB 2527 would create a sustainability fee for the connector
- HB 2529 would transition the Hawaii Health Connector to a state entity
- HB 2530 would reduce the size of the board to 12, with no more than nine voting members

- HB 2531 would require greater transparency, including open meetings, notices, and an annual report. Read more.

Kansas

Kansas Nurses Seek Expanded Role. A January 27, 2014 Kansas Health Institute article highlights a scope-of-practice bill that would allow advanced practice registered nurses (APRNs) to diagnose, treat, and prescribe medications for patients without physician oversight. The primary emphasis is to expand the supply of primary care providers to improve access to care. The Kansas Medical Society has expressed its opposition. Read more.

Kentucky

Kentucky Senate GOP Aims to Curb Governor's Power. On January 27, 2014, Kentucky Public Radio posted an article discussing the efforts of State Senate Republicans to limit the ability of Democratic Governor Steve Beshear to pursue major policy initiatives—such as Medicaid expansion and the creation of a state health exchange—without legislative assent. Republicans have drafted Senate Bill 1 to approve an amendment to the state's constitution that would limit gubernatorial power to issue executive orders. Governor Beshear notes that the legislature should not be in the business of running the state government on a day-to-day basis, and that the legislature is empowered to overturn regulations by passing bills. Read more.

Maine

Maine's HHS Department Deficit Likely $30 Million Less than Projected. On January 24, 2014, Health and Human Services Commissioner Mary Mayhew told a legislative committee that the department's budget deficit is likely to be $30 million less than originally projected: about $78 million, down from $108 million. Most of the shortfall comes from increased utilization by MaineCare beneficiaries, despite a decline in enrollment. Mayhew did reflect that a small subset of Medicaid beneficiaries disproportionately drive spending, namely those with intellectual and developmental disabilities, the elderly, and the severely mentally ill. While national Medicaid spending is projected to grow 7 percent, Mayhew estimates that Maine's Medicaid spending will rise less than 1 percent. Read more.

Maryland

Maryland Small Businesses to Offer Small Group Health Plans in April. On January 27, 2014, Maryland approved a plan enabling small businesses to offer small group health plans in April, six months after the original target launch, due to state exchange technological glitches. However, the launch of the small business health care exchange website has been delayed to January 1, 2015, in line with the federal health exchange. Thirteen carriers offer qualified health plans approved for sale on the state's SHOP Exchange. Tax credits worth up to 50 percent of the employer's contribution toward employee premium costs will be available directly through carriers, third party administrators, and brokers starting April 1, 2014. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

Study Highlighting Benefits of Hospital Consolidation May Affect Partners/South Shore Deal. A January 23, 2014 study released by the Federation of American Hospitals indicated that hospital consolidation yields more integrated health systems, lower costs, and improved care. This study could have implications for the bid by Partners HealthCare to acquire South Shore Hospital in Weymouth. The study contends that consolidation brings efficiencies necessary to deal with reimbursement cuts, risk-based payments, and heavy technology investments. Other recent studies have found that the elimination of competition has led to price increases and narrower networks that drive provider concentration. The Health Policy Commission is expected to issue a final report on the Partners deal next month. Read more.

Cooley Dickinson Names Marqusee CEO. On January 21, 2014, Cooley Dickinson Hospital named Joanne Marqusee, COO of Hallmark Health since 2009, to be its next president and CEO starting March 31, 2014. Marqusee succeeds Craig Meilin, who retires from Cooley Dickinson on Jan. 31, and chairman Matthew Pitoniak, who will assume the role of interim CEO until March 31. Previously, Marqusee was SVP of operations at Beth Israel Deaconess Medical Center and held various positions in New York City's Health and Hospitals Corp. and New York State's Department of Health. Read more.

Missouri

Missouri Court Blocks Navigator Restrictions. On January 23, 2014, District Court Judge Ortrie Smith issued a preliminary injunction that prevents the Missouri Department of Insurance from enforcing a state law that restricts healthcare navigators that lacked licenses in the state from enrolling the uninsured in health plans. Smith wrote that state laws that place a burden on the operation of federally facilitated exchanges run counter to the Affordable Care Act and "are subject to pre-emption." Read more.

Retired Senator Bond Lobbies for Medicaid Expansion. On January 24, 2014, St. Louis Public Radio reported that retired U.S. Senator Christopher "Kit" Bond has been hired by the Missouri Chamber of Commerce to lobby Republican legislators to support Medicaid expansion in the state. Bond acknowledged his opposition to "Obamacare" but emphasized that rejecting Medicaid expansion dollars would hurt hospitals and business in the state. Bond notes that Missouri rural hospitals could lose $58 million in federal DSH money in 2014, which could grow annually to $208 million by 2019. Read more.

New Hampshire

New Hampshire Bill Would Require Negotiations with "All Willing" Providers. In a January 28, 2014 state House committee meeting, two hospital executives testified that they should have been given an opportunity to negotiate with Anthem Blue Cross and Blue Shield of New Hampshire, currently the only carrier on the state's health exchange. Representative Bill Nelson sponsored legislation to ensure health plans negotiate with all willing providers in order to allow continuity of care. Anthem argues that its provider network already includes nearly three-quarters of the state's primary care providers, 85 percent of specialists, and 16 of the state's 26 hospitals. Anthem

believes that including all hospitals could increase premiums by 30 percent since there would be less inclination on the part of providers to accept negotiated discounts. Read more.

New Jersey

HMA Roundup – Karen Brodsky

Legislation to Monitor Medicaid MCO Provider Reimbursement Rate Changes Vetoed by Governor Christie. On January 21, 2014, Governor Chris Christie vetoed a bill (2012:A3409) that would have required Medicaid managed care organizations (MCO) in New Jersey to obtain approval from the Commissioner of the Department of Human Services before reducing provider rates. The legislation was prompted by the swift 2012 reduction in reimbursement rates to home care providers by Horizon NJ Health, the largest contracted Medicaid MCO. Advocates for the legislation believed this bill would have afforded protections for Medicaid enrollees by introducing critical oversight and examination of MCO actions on provider rates. Home health agencies report that it has been difficult to recruit and retain home health aides under the reduced reimbursement rates. Meanwhile, the state performs quarterly provider network adequacy reviews and monitors enrollee complaints to ensure good access to providers. Read more.

New PCA Assessment Tool to Go Live July 1, 2014. The Division of Medical Assistance and Health Services (DMAHS) is developing and testing a new PCA Assessment Tool for individuals who have been referred for personal care assistant (PCA) services to be used by all contracted Medicaid Managed Care Organizations (MCOs). The tool was developed by a workgroup of representatives from DMAHS, the Division of Aging Services and the Division of Disability Services. It is currently being reviewed by the Medicaid MCOs. They will begin using the tool in a beta testing period in March and April 2014 with an expectation of go-live in July 2014 when the state implements managed long term services and supports. The tool gathers information about the person and their household, diagnosis and/or limitations resulting in the need for PCA services, an assessment of their activities of daily living and independent activities of daily living, and includes a nursing summary. Read more.

Autism Spectrum Disorder (ASD) Program to Begin in Spring 2014. New Jersey's Comprehensive Medicaid Waiver includes a small program for children with Autism Spectrum Disorder (ASD) that provides access to services not otherwise covered by Medicaid. This program will limit services to 200 children at any point in time and is scheduled to begin by the end of March 2014. To be eligible to receive ASD-related services a child must meet the following criteria:

- Be determined developmentally disabled, or "DD" eligible through the New Jersey Children's System of Care (CSOC) initiative in the Department of Children and Families
- Be a Medicaid/NJFamilyCare eligible youth
- Be under 13 years of age
- Meet the ASD level of care criteria
- Have a diagnosis of ASD

The New Jersey Department of Children and Families (DCF), Children's System of Care, CSOC, (formerly the Division of Child Behavioral Health Services) serves children and adolescents with emotional and behavioral health care challenges and

developmental and intellectual disabilities, as well as their families. Children with other forms of health insurance are excluded from the ASD Program since services for ASD are otherwise covered by commercial health plans in New Jersey.

Depending on the child's level of acuity, they will qualify for one of three levels of care:

1. Low acuity – up to $9,000/year coverage
2. Moderate acuity – up to $18,000/year coverage
3. High acuity – up to $27,000/year coverage

PerformCare NJ serves as CSOC's contracted systems administrator and will conduct tier assessments and determine the level of care needed. CSOC will then authorize with its own provider network, behavior consultative supports, and individual behavior supports. When a child under the ASD program needs services to address ASD that would be provided by physical, occupational, or speech therapists, their NJ FamilyCare managed care organization will authorize and cover the service. Questions on eligibility, enrollment, and coverage under the ASD Program can be emailed to dcf_cbh@dcf.state.nj.us.

Telepsychiatry Now a Covered Service Under NJ Medicaid. As New Jersey hospital and independent clinic mental health providers have expressed concerns with the growing shortage of psychiatrists and psychiatric advance practice nurses (APNs) across the state, they maintained that this shortage has driven up costs and reduced access to appropriate psychiatric care. The Centers for Medicare and Medicaid Services (CMS) has determined that the provision of telemedicine services may meet the definition of face-to-face services and has permitted states to allow telemedicine as a billable service, provided certain criteria are met. By allowing telepsychiatry for the face-to-face provision of mental health services provided by psychiatrists and psychiatric advance practice nurses at independent clinic mental health programs and hospital outpatient mental health programs, DMAHS hopes to ameliorate the difficulties that providers have expressed in obtaining psychiatric services.

New York

HMA Roundup—Denise Soffel

Vital Access Provider Program Funds. On January 27, 2014, Governor Andrew Cuomo announced $56 million in funding to ensure healthier communities across the State through the Vital Access/Safety Net Provider Program (VAP), which supports healthcare services for New York State's fragile, elderly, and low-income populations. This round of funding brings the program's total to $157 million, and will be used primarily to improve community care, including expanding access to ambulatory services, opening urgent care centers, expanding services in rural areas, and providing more effective services that meet community needs. These awards support multi-year projects submitted by hospitals, nursing homes, free standing clinics, and home health providers. Read more.

Sebelius Responds to Cuomo Concerns About 1115 Waiver. In a January 22, 2014 letter to Governor Cuomo, HHS Secretary Kathleen Sebelius noted that CMS has begun drafting the terms of a potential agreement for an 1115 demonstration to invest additional funding in New York's health care delivery system; however, the letter contained no details about the potential agreement. Secretary Sebelius noted that the intent of the waiver was not to support financially distressed, failing hospitals, but rather to improve the health of Medicaid beneficiaries and lower health system costs

through health delivery transformation. Secretary Sebelius invited Cuomo's team to discuss waiver issues in Washington. Read more.

Proposed Legislation on Out-of-Network Provider Billing. Governor Cuomo's executive budget includes a proposal that would address the issue of "surprise" billing for out-of-network providers. The bill comes in response to consumers receiving bills from providers, particularly in an inpatient setting, from a provider that they did not realize was an out-of-network provider. The thrust of the proposal is to take the consumer out of the negotiation between an insurer and an out-of-network provider in instances when the consumer did not have advance notice that the provider was out of network, and was not given the opportunity to choose an in-network provider. The proposal would allow consumers to assign their benefits over to the provider, and place the dispute between the provider and the insurer. In addition, it outlines a dispute resolution process and imposes disclosure requirements on doctors and hospitals to inform consumers when a provider is out-of-network. The proposal also introduces improved network adequacy requirements for health plans, and in cases where the network is inadequate, would allow the consumer to receive out-of-network care at the in-network price. Read more.

North Carolina

North Carolina DHHS Reports Increase in Medicaid Claims Payments Over Prior Year. In a January 28, 2014 article, the Triangle Business Journal reports that the NCTracks system has paid out more claims than in the comparable prior year period, according to the NC Department of Health and Human Services. That said, claims denials are far higher for individual physicians, as compared to pharmacies, healthcare facilities, and dental providers. Read more.

Oregon

Cover Oregon Enrollment in Private Plans Tops 30,000. According to a January 24, 2014 enrollment update, Cover Oregon has enrolled 30,157 Oregonians in private health insurance through the health exchange, with another 53,018 enrolled in the Medicaid-funded Oregon Health Plan using the exchange. In addition, 121,190 Oregonians were enrolled in the Oregon Health Plan using the Oregon Health Authority "Fast Track" process, which bypassed the exchange entirely. Read more.

Pennsylvania

HMA Roundup –Matt Roan

HHS Agrees to Delay CHIP Enrollment Shift to Medicaid; Congressman Introduces a Bill for a Permanent Fix. Last week, the PA Department of Insurance announced that the Corbett Administration has reached an agreement to allow children in the state's CHIP program from families with incomes less than 133 percent of FPL to remain in CHIP until December 31, 2014, rather than transitioning to Medicaid. The transition of low income children from CHIP to Medicaid is required as part of the ACA. Corbett officials had been negotiating with HHS to prevent the shift citing concerns about the availability of providers in the Medicaid program. Under the agreement, parents of CHIP enrollees will be able to choose to stay in CHIP, while new children under 133 percent of FPL will go directly to Medicaid. Meanwhile, Congressman Charlie Dent has introduced a bill in Congress which would allow states to maintain low income children in their CHIP programs permanently. Read more. Read more.

Hospital, Homecare Associations Announce Forum on Healthcare Reform. Last week, the Hospital Association of PA and the PA Homecare Association announced a collaborative effort to establish a policy forum on healthcare reform issues. The Pennsylvania Home Health and Hospice Forum will deal with topics including care transitions, chronic care management, medical homes, and consumer and family-focused care with a focus on collaboration and coordination of care. The forum will provide education to members of both associations on regulatory and programmatic changes that are the result of the many healthcare reform initiatives currently being implemented. Read more.

Employment Picture in Pennsylvania Mixed. On January 24, 2014, the Pennsylvania Department of Labor and Industry reported that the December unemployment rate in PA dropped from 7.3 percent to 6.9 percent, representing the largest sequential decline since 1983. The reasons for the decrease are less clear, however economists have said that a large portion of the decline is driven by unemployed residents withdrawing from the workforce. The two employment surveys that comprise monthly statistics appear to be contradictory. A Household survey reveals approximately 12,000 newly employed residents, while employer surveys show that 11,400 jobs have been cut. The number of people withdrawing from the workforce contribute to the overall calculation of unemployment resulting in a lower rate. Read more.

FQHCs Concerned with Healthy PA Plan. On January 24, 2014, the Pennsylvania Association of Community Health Centers—which represents FQHCs and Community Health Clinics—raised concerns with Governor Tom Corbett's Healthy PA Medicaid reform proposal. The plan would extend coverage to residents in the "Medicaid Expansion" population through private health insurance options. While the new insurance plans are expected to include FQHCs in their provider networks, the proposal allows plans to negotiate payment rates with the clinics rather than following the Prospective Payment System (or PPS) rate currently in place. The Association argues that the population that would have access to coverage through Healthy PA are currently being served in Community Health Clinics, and that lower reimbursement rates could cause some centers to close. Without the services provided by FQHCs, the Association says that access to care will become an even greater challenge for low income Pennsylvanians. Read more.

South Carolina

South Carolina Hospital Financial Data Unveiled. On January 27, 2014, the South Carolina Medicaid agency unveiled a website (www.SCHealthData.org) that details the financial data of the state's 60 hospitals, bringing transparency and, eventually, comparison shopping to healthcare consumers. So far, people can search for five years of financial data on hospitals' profitability, occupancy levels, and experience in treating uninsured residents. By the spring, hospital pricing should become available for various services. Read more.

South Dakota

South Dakota Legislators Discuss Medicaid Expansion. On January 24, 2014, South Dakota legislators discussed the possibility of Medicaid expansion, although such a move would likely require Federal flexibility on program design. The Associated Press quotes Representative Bernie Hunhoff, House Democratic minority leader, as indicating that he was "confident we can do something on Medicaid this session." Representative Justin Cronin, a House Republican assistant majority leader, noted

reluctance on the part of federal officials in accepting Governor Dennis Daugaard's more limited expansion proposal to a limited group (up to 100 percent of FPL income). Hunhoff indicated legislators will begin to draft Medicaid expansion bills in the next week. Read more.

Tennessee

Department of Intellectual and Developmental Disabilities (DIDD) Budget Cuts Remain "Painful". In a January 23, 2014 meeting with The Tennessean's editorial board, Department of Intellectual and Developmental Disabilities chief Debra Payne called the deep budget cuts to the agency "painful," noting that 40 percent of all state employee positions eliminated since 2006 have been at DIDD. With more than 7,100 people with intellectual disabilities on a waiting list for services and thousands more with developmental disabilities unable to access care, the state would have to pony up more than $250 million to provide services to both groups (or about 80 percent more than current spending levels). Governor Bill Haslam submitted a budget plan that would further cut the department's spending by $15 million in the next fiscal year. Read more.

Texas

HMA Roundup –Dianne Longley

Parkland Hospital CEO Finalists Announced. On January 13, 2014, Parkland Hospital announced three finalists in its lengthy search for a new CEO. The finalists are: Frederic Cerise, MD, currently serving as associate clinical professor of medicine at Louisiana State University and former head of the Louisiana public hospital system; David Lopez, resident and CEO of the Harris County Hospital District, the fifth largest public health care system in the country; and Marlon Priest, MD, executive VP, chief medical officer, and market lead for senior services at the Bon Secours Health System in Marriottsville, Md., and former professor and medical director for the University of Alabama. Parkland has been searching for a new leader since December 2011, when Dr. Ron Anderson stepped down after the Board refused to renew his contract. In August, 2011, CMS issued a pending notice of termination of federal funds amid several high-profile performance problems that eventually led to a Systems Improvement Agreement between CMS and Parkland and allowed the hospital to continue providing services to Medicare and Medicaid patients while working on a correction plan. The hospital was released from the agreement in August as it satisfied CMS requirements. The ongoing problems contributed to the lengthy search and several delays in the selection of a new CEO. Read more.

HHSC Dual Demonstration Project Details Nearly Complete. At a public stakeholder meeting on January 21, 2014, HHSC announced that the state is close to finalizing dual demonstration project details with CMS. Consistent with the application, HHSC plans to implement a fully integrated, capitated approach that requires a three-party agreement between MCOs that have both an existing STAR+PLUS contract and a Medicare Advantage Special Needs Plan contract with the federal government. The three-party agreement will be between the MCO, the state, and CMS for the provision of a full array of Medicaid and Medicare services. HHSC stated MCO participation will be voluntary. The pilot will likely be limited to the following six counties: Bexar (San Antonio), Dallas, El Paso, Harris (Houston), Hidalgo, and Tarrant (Ft. Worth).

HHSC hopes to begin the project by January 15, 2015. The three year pilot will run through 2017. The state is working on a roll-out strategy that includes a consumer outreach program beginning at least 60 days prior to implementation. Eligible clients will be allowed to opt-out of the demonstration. HHSC expects to complete the MOU with CMS by the end of February; contracts with participating MCOs will be finalized by August, 2014, and client notification will begin in October/November 2014. HHSC has been in negotiations with CMS since the proposal was submitted to CMS in May, 2012. Read more.

Managed Care Expansion Initiative Update. HHSC continues to host a series of stakeholder meetings throughout the state to provide updates on plans for Medicaid managed care expansions and other initiatives being implemented in response to legislation enacted in 2011 and 2013. Major initiatives occurring during the next two years include the following:

- **STAR+PLUS expansion into Medicaid Rural Service Areas (MRSA)** – roll out scheduled for September 1, 2014; contracts awarded last year to Superior (Centene), United Healthcare, Cigna-Health Spring, and Amerigroup. Expected to serve an additional 80,000 members in STAR+PLUS.
- **Behavioral Health services carve-in to managed care** – implementation is scheduled for September 1, 2014. Covered mental health rehabilitation and case management services currently provided through fee-for-service will be included. Enacted legislation also requires HHSC to establish two behavioral health home pilots; create a Behavioral Health Integration Advisory Committee; create community collaboratives for individuals who are homeless and have a mental illness condition and/or substance abuse problem; and establish and maintain a mental health substance abuse treatment public reporting system.
- **Intellectual and Developmental Disabilities (IDD) managed care carve-in** – scheduled for September 1, 2014. Includes individuals currently receiving services in community-based Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions (ICF-IID) and Individuals receiving services in ICF-IID 1915(c) waivers, including Home and Community Services, Community Living and Support Services, Texas Home Living, and Deaf Blind Multiple Disabilities. Carve-in does NOT include individuals residing in a state-supported living center or dual eligibles. Children and young adults under 21 receiving SSI or SSI-related services are voluntary.
- **Nursing Facility managed care carve-in** – scheduled for September 1, 2014. Nursing facility services will be provided/managed through STAR+PLUS MCOs. HHSC expects approximately 60,000 nursing facility residents will be affected by the transition. It includes adults age 21 and older who are in a nursing facility, who have been determined eligible for Medicaid, and who meet STAR+PLUS criteria. Children and young adults under age 21 will be excluded. DADS (Department of Aging and Disability Services) will continue to coordinate and oversee many of the services currently under their jurisdiction. MCOs will contract directly with nursing facilities and oversee appropriate utilization of services. HHSC will set minimum reimbursement rates, which includes the staff payment rate enhancement enacted by the Texas Legislature. HHSC is working closely with MCOs and nursing facilities to ensure a smooth transition and is urging MCOs to aggressively work on contracting with nursing facilities to minimize the number of patients who will have to be moved.

Additional details are available in the following HHSC presentation here.

STAR Kids Update. HHSC is beginning plans for the rollout of STAR Kids, a Medicaid managed care model designed for children and young adults with special needs and required by legislation. The program will move most children and young adults under the age of 21 who get SSI Medicaid or home and community-based waiver services into managed care. Enrollees will receive comprehensive service coordination; services will include personal care, private duty nursing, therapies, medical supplies and equipment, and behavioral health services. Children and youth enrolled in the Medically Dependent Children Program and children enrolled in the Youth Empowerment Services mental health and substance abuse waiver will receive all of their services (LTSS and acute care) through STAR Kids. Individuals who receive services through other home and community-based programs administered by DADS will continue to receive LTSS through that program, but will receive acute care through STAR Kids. The state had initially anticipated issuing the RFP in January 2014, but now expects to release a draft RFP by "early spring," with a final RFP issued by "early summer." Implementation is still scheduled to begin September 1, 2015.

New Navigator Rules Enacted by Texas Department of Insurance. In response to legislation enacted in 2013 (Senate Bill 1795), the Texas Department of Insurance adopted final rules requiring additional requirements for individuals working as insurance exchange navigators. The rules require navigators to complete an additional 20 hours of education courses that consist of TDI-certified training on the state's Medicaid and CHIP programs, privacy requirements, ethics, basic insurance terminology and training, and exam preparation. Individuals must also pass a final examination. The rules also require individuals to pass a background check and provide proof of identity. Although the initial draft rules required registration fees of up to $800, those fees were eliminated in the final version in response to negative feedback from individuals testifying at the rule hearing. Organizations that perform or oversee navigators must also provide evidence of financial responsibility. Both organizations and individual navigators must register with TDI. Individuals have until March 1, 2014 to register and May 1, 2014 to complete the training and examination.

Utah

Utah Governor Supports Medicaid Expansion. On January 23, 2014, Governor Gary Herbert declared support for Medicaid expansion in the state, saying that "doing nothing is not an option." Herbert pledged to work with the legislature on the design of the program. Members of the state's Health Reform Task Force have recommended a private option approach, similar to that of Arkansas, but the format could take two approaches:

- A premium assistance model for Utah residents with income below the poverty level and exchange subsidies for those over the FPL income threshold.
- A premium assistance model for the entire expansion population up to 138 percent of FPL income. Read more.

Virginia

Virginia House of Delegates Leaders Reject Medicaid Expansion. On January 27, 2014, Republican House of Delegates leaders rejected Medicaid expansion this year, setting up a showdown with newly elected Governor Terry McAuliffe. Instead, GOP leaders called for a comprehensive audit of the Medicaid program and patience in

evaluating the effectiveness of reform proposals. Republicans cited waste, fraud, and inefficiency in the program, but Democrats countered that the largesse of full federal funding for the expansion population was the fiscally responsible approach in cutting state spending and creating jobs. Read more.

Study Indicates $1 Billion in Savings to the State by Expanding Medicaid. In a study released last week by Virginia's Health and Human Resources Secretary William Hazel, Virginia would be expected to save more than $1 billion through 2022 by accepting Medicaid expansion, Governor McAuliffe's top priority. Hazel briefed the General Assembly finance committee, while the Department of Medical Assistance Services explained the findings in a letter to the Medicaid Innovation and Reform Commission. Read more.

Washington

HMA Roundup—Doug Porter

State Senator Proposes Budget Neutral Approach to Helping the Developmentally Disabled. In a January 24, 2014 article, the News Tribune explored Senate Ways and Means Committee Chairman Andy Hill's bill, the Vulnerable Individuals Priority Act (S.B. 6387), which asserts that Washington state could slash the three and a half year wait list for services for the developmentally disabled without spending more state funds. The approach Hill advocates would emphasize respite services, which would qualify for 6 percent higher federal match under the Community First Choice Option. In turn, Hill believes that 4,000 families would qualify for respite care services, thus avoiding institutionalization. In addition, the bill could help approximately 1,000 people find work. Moreover, Hill believes that the true wait list of people who maintain eligibility and are seeking services is closer to 5,300, not 15,000. Read more.

National

HHS Says 6.3 Million Determined Eligible for Medicaid Since October 1. Since the October 1, 2013 launch of the federal and state enrollment period for the Marketplaces and state Medicaid programs, the Department of Health and Human Services (HHS) reports that 6.3 million Americans have been determined eligible for Medicaid. However, due to continued issues with the enrollment verification systems, HHS cannot confirm how many of the 6.3 million have actually enrolled. Additionally, Reuters quotes Matt Salo, the executive director of the National Association of Medicaid Directors (NAMD), as saying that "this number also can include people in some states who are eligible under pre-expansion -- the woodwork effect -- and whose Medicaid enrollment was simply renewed." Read more.

Jackson Hewitt Report Quantifies Employer Tax Penalties in States not Expanding Medicaid. A report issued last week by Jackson Hewitt Tax Service suggests that employers in states electing not to expand Medicaid could pay between $1.03 and $1.55 billion in federal tax penalties beginning in 2015. The report outlines how the penalties will likely impact employers with fifty or more employees in each of the 25 states that have not yet expanded Medicaid. Link to Report.

Industry News

WellPoint Reports Half Million in Marketplace Enrollees. In WellPoint's year-end financial report, announced January 29, 2014, the company indicated it has received higher-than-anticipated enrollment through the state and federal Marketplaces, roughly 500,000 total enrollees. Additionally, WellPoint indicated that more than half have already paid their first month's premium and that the company expects the Marketplace enrollment sector to be profitable in 2014. WellPoint did not disclose specific enrollments by state. Read more.

WellCare Names National Health Plans President. On January 27, 2014, WellCare announced that Kenneth A. Burdick has been named the company's president of national health plans. In this role Burdick will oversee all of the company's health plans and product lines. Most recently, Burdick served as president and CEO of Blue Cross and Blue Shield of Minnesota. Read more.

CareSource Adding 1,000 Medicaid Waiver Enrollees in Southeast Ohio. CareSource announced an agreement with Ohio's Medicaid department to expand coverage to an estimated 1,000 new beneficiaries in southeast Ohio under a partnership with three Area Agencies on Aging in the region. According to *Dayton Business Journal*, CareSource will provide case management for the Home Care and Transitions Carve-Out Waiver program, which provides personal care, nursing, day health, and out-of-home respite services. Read more.

Community Health Systems Completes Health Management Associates Acquisition. On January 27, 2013, Community Health Systems announced it has completed its acquisition of hospital management company Health Management Associates (unrelated), a deal which was announced on July 30, 2013. With the acquisition finalized, Community Health Systems operates 206 hospitals across 29 states. Read more.

Health Net Completes Three-Way Duals Demonstration Contract for LA and San Diego Counties. On January 22, 2014, Health Net announced that its subsidiary health plan, Health Net Community Solutions, has entered into a contract with CMS and California's Department of Health Care Services (DHCS) for the state's dual eligible financial alignment demonstration, known as Cal MediConnect, in Los Angeles and San Diego counties. The implementation of coverage will begin no earlier than April 1, 2014, according to Health Net's release. Read more.

Hearst Corporation Announces Creation of Hearst Health. Hearst Business Media president Richard Malloch announced the creation of the Hearst Health division, incorporating its existing health information companies First Databank, Zynx Health, MCH Homecare Homebase, and Map of Medicine. Hearst Health's care guidance is used by health plans, health systems, and homecare and hospice agencies, among other providers, according to Mr. Malloch. Read more.

RFP Calendar

Date	State	Event	Beneficiaries
January, 2014	Delaware	RFP Release	200,000
January, 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,538
February 27, 2014	Georgia ABD	Proposals Due	320,000
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Passive enrollment begins	456,000
April 1, 2014	Ohio Duals	Passive enrollment begins	115,000
April 17, 2014	Texas NorthSTAR (Behavioral)	Proposals due	406,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Illinois Duals	Passive enrollment begins	136,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
July 1, 2014	Michigan Duals	Implementation	70,000
July 7, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	406,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	New York Duals	Passive enrollment begins	178,000
September 1, 2014	Washington Duals	Passive enrollment begins	48,500
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	406,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; 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; WellPoint/Amerigroup
Colorado	MFFS	62,982						7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	3/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho	Capitated	22,548	X	TBD	August 2013			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri	MFFS‡	6,380					10/1/2012		
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013			TBD	
South Carolina	Capitated	68,000	X			10/25/2013	2/1/2014	7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2014	9/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**12 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Welcomes: Capri Dye – Washington, DC

Capri Dye joins HMA's Washington, DC office as a senior consultant. Capri comes to us most recently from Hubbert Systems Consulting (HSC) where she has worked the last eight years. Her latest role with them has been as a Business Consultant. Capri's work was heavily involved in HIT systems and correctional health. Her projects included working with the CMMI Institute in the preparation, piloting, and delivery of whole product components such as appraisals, consulting engagements, communication mechanisms, user guidance, job aids, and data analysis. Another project that Capri was involved in was with CMS for the HITECH Evaluation Project/EHR Incentive Program. In this role she helped provide project management, business process, and subject matter expertise to develop and deliver the CMS HITECH evaluation for the EHR Incentive Program. This included identifying and documenting State Medicaid EHR processes, systems, and technology platforms, quality management activities, and current/future initiatives in order to measure the current maturity of the State's EHR Incentive Program. The project also involved assisting CMS in understanding the Correctional Health Care Provider population and the challenges that may exist as they register for the program. Additional projects that Capri worked on at HSC were the State of HI Medicaid Information Technical Architecture State Self-Assessment, State of IN and State of TN Medicaid HIT IAPD and SMHP Update, and Infocrossing MMIS Assessment and MMIS Roadmap.

Prior to joining HSC Capri worked as an Independent Consultant with CSD Marketing; the Executive Director for the Reno Builder's Exchange; the Marketing/Proposal Coordinator for DPR Construction; and the Marketing Coordinator for NetStream Communications.

Capri received her Bachelor's Degree in Business Management from Golden Gate University. She has also completed certification coursework for CMMI in both Development and Services.

HMA's Accountable Care Institute Releases New Toolkit

HMA's Accountable Care Institute (ACI) is continually working to assist publicly funded health care systems transition into the realm of integrated, accountable systems of care. Unmatched expertise, shared experiences, and practical tools converge in HMA's ACI – a venue to develop, support, and disseminate innovations in accountable care. Check out the resources available in the ACI Toolkit: Link to ACI Toolkit.