

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... May 30, 2018



[RFP CALENDAR](#)

[HMA News](#)

Edited by:

Greg Nersessian, CFA
[Email](#)

Annie Melia
[Email](#)

Alona Nenko
[Email](#)

Nicky Meyyazhagan
[Email](#)

THIS WEEK

- [IN FOCUS: NORTH CAROLINA PREPAID HEALTH PLANS POLICY PAPER](#)
- [WASHINGTON ANNOUNCES MEDICAID MCO RFP AWARDS](#)
- [FLORIDA TO ENACT CUTS TO CORRECTIONAL TREATMENT PROGRAMS](#)
- [UTAH TO VOTE ON MEDICAID EXPANSION BALLOT MEASURE IN NOVEMBER](#)
- [VIRGINIA SENATE APPROVES MEDICAID EXPANSION](#)
- [MINNESOTA SEEKS WAIVER TO USE MEDICAID FUNDING FOR RESIDENTIAL DRUG TREATMENT](#)
- [WELLCARE HEALTH PLANS TO ACQUIRE MERIDIAN FOR \\$2.5 BILLION](#)
- [UPCOMING WEBINAR: PARTNERSHIP OPPORTUNITIES FOR PAYERS, PROVIDERS AND STATES: SUPPORTIVE HOUSING FOR HIGH UTILIZERS, JUNE 7, 1-2 EDT](#)
- [HMA WELCOMES: MARGARET WILLIAMS \(DENVER\)](#)
- [NEW THIS WEEK ON HMA INFORMATION SERVICES \(HMAIS\)](#)

IN FOCUS

NORTH CAROLINA PREPAID HEALTH PLANS POLICY PAPER

This week, our *In Focus* section reviews the North Carolina Department of Health and Human Services (DHHS) Medicaid Managed Care Proposed Policy Paper released on May 16, 2018, *Prepaid Health Plans in North Carolina Medicaid Managed Care*. This policy paper identifies key programmatic details ahead of a competitive procurement for the new Medicaid managed care program expected to be released in the summer of 2018. North Carolina will be contracting with statewide Medicaid managed care organizations (Commercial Plans, CPs) as well as regional provider-led managed care entities (Provider-Led Entities, PLEs) to serve 1.9 million Medicaid beneficiaries beginning in 2019. All plans are considered by the state to be Prepaid Health Plans (PHPs).

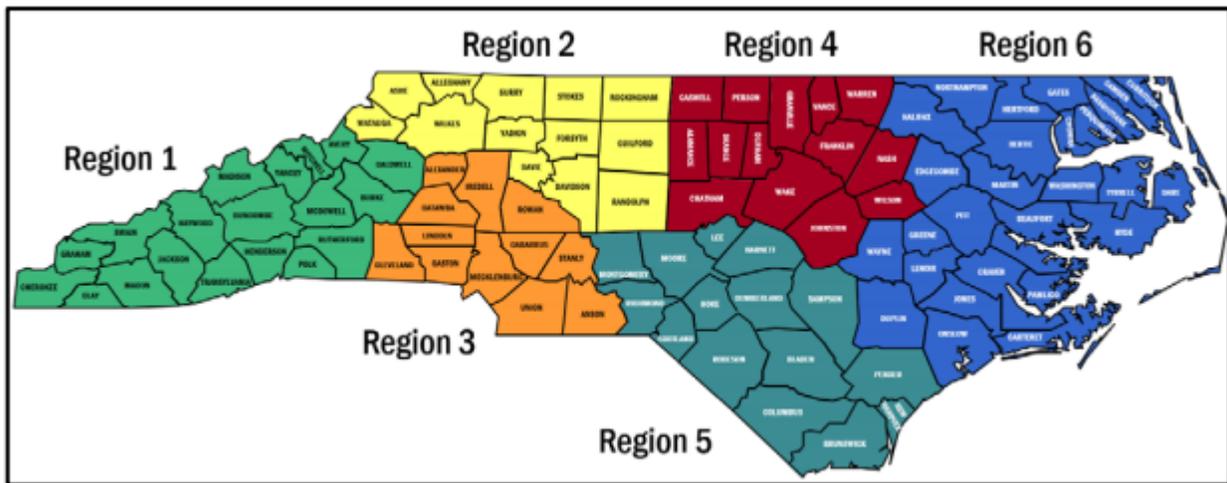
The policy paper provides additional detail on the characteristics and requirements that apply to CPs and PLEs. To read HMA’s previous analysis of “North Carolina’s Proposed Program Design for Medicaid Managed Care,” click [here](#).

PHP Requirements

North Carolina DHHS will award three statewide capitated PHP contracts and up to 12 capitated PHP contracts with PLEs to provide coverage by region. DHHS will encourage PLEs to bid on more than one region. It will also encourage PLEs to participate in other North Carolina insurance markets, including the individual health insurance marketplace. The request for proposals (RFP) is expected to include an opportunity for PHPs to make a commitment to offer Qualified Health Plans (QHPs) on the Federally Facilitated Marketplace (FFM). DHHS will grant points to RFP respondents for their commitment to participate, for their current participation status, and for their expected footprint in North Carolina in 2021.

PHPs will not need prior experience serving as a health plan to bid on the PHP procurement and may therefore be a newly-formed organization. Additionally, PHPs may be formed by joint ventures or other partnerships between managed care organizations, health care providers or other organizations.

There are a total of six regions in the state:



Enrollment Limits

Selected plans in each region will have enrollment minimums and maximums for auto assignment. A region's enrollment floor will be the greater of 10 percent market share or 20,000 lives and the enrollment ceiling will be 50 percent market share. The table below shows a breakdown per region.

Region	Average Lives	Auto-assignment floor (greater of 10% or 20k)	Auto-assignment ceiling (50%)
1	140,000	20,000	70,000
2	260,000	26,000	130,000
3	370,000	37,000	185,000
4	300,000	30,000	150,000
5	260,000	26,000	130,000
6	210,000	21,000	105,000

Covered Populations

Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs. However, mandatory enrollment for high-need populations will be phased in after the Medicaid managed care program is fully established. After full implementation of the managed care program, the following populations will be covered:

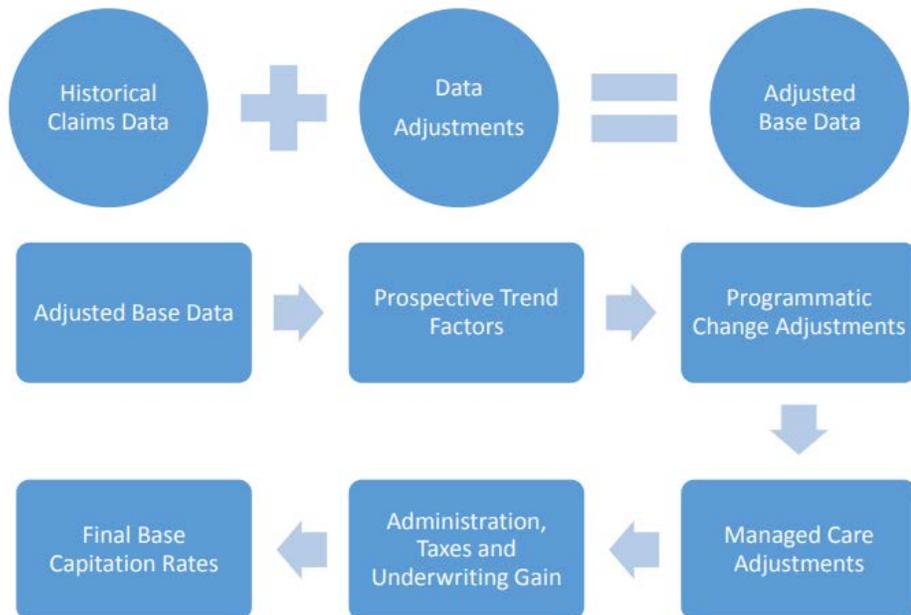
1. AFDC and related MAGI populations
2. Aged, Blind, and Disabled populations
3. NC Health Choice and Medicaid-Expansion Children's Health Insurance Program (MCHIP)
4. Legal Aliens
5. Long-term services and supports populations
6. Foster Children, Adoption Children, and Former Foster children
7. Dual eligibles (excluding partial duals and pending legislative change)

Meanwhile, the following populations will be excluded:

1. PACE beneficiaries
2. Medically needy beneficiaries
3. Beneficiaries only eligible for emergency services
4. Presumptively eligible beneficiaries, during the period of presumptive eligibility
5. Beneficiaries eligible for Medicare, but not full Medicaid benefits
6. Health Insurance Premium Payment (HIPP) beneficiaries

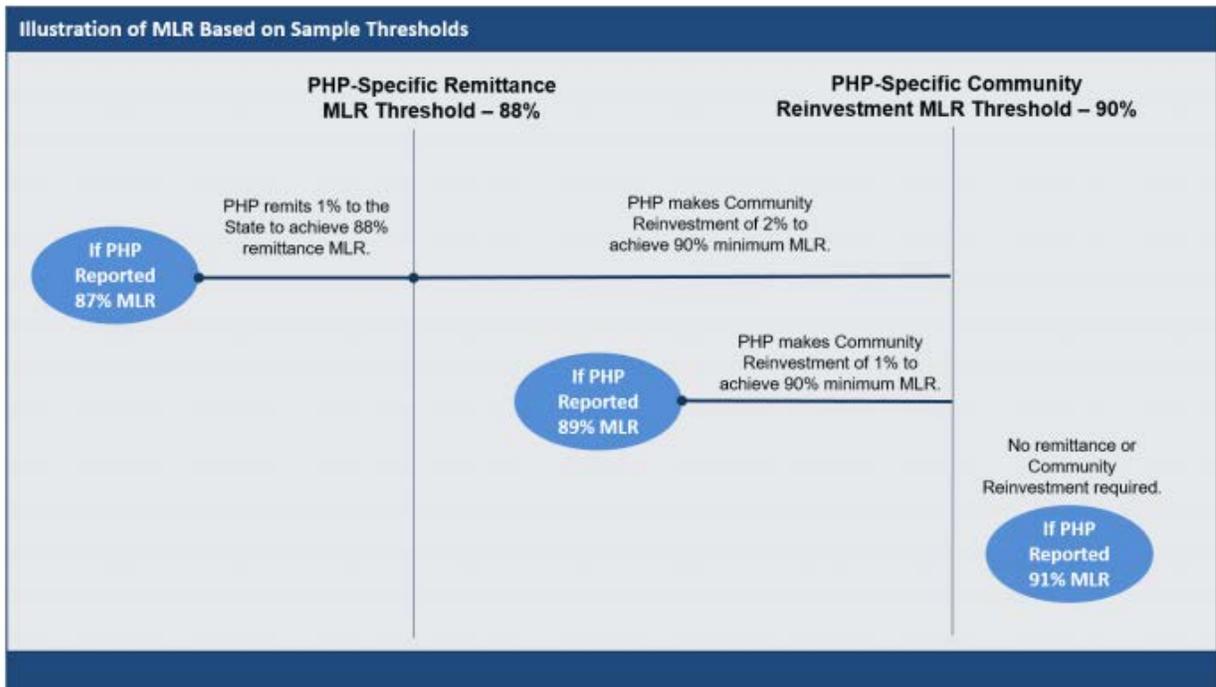
Capitation Rate Setting

DHHS will set capitated rates for all PHPs. It will provide draft capitation rates as part of the PHP RFP. As a result, PHPs will not submit price bids in conjunction with the RFP. The capitation rates will include an assumed underwriting gain of 1.75 percent of premium: 1.25 percent for the cost of capital and a risk margin of 0.5 percent. PHPs will be required to accept the rate setting and risk adjustment methodologies. The capitated rate-setting methodology will be based on the following elements:



Minimum Medical Loss Ratio

DHHS expects to set a remittance Medical Loss Ratio (MLR) threshold of approximately 88 percent and an overall minimum MLR threshold of approximately 90 percent. It will adjust the MLR thresholds by PHP based on the specific populations covered. To prevent PLEs from anti-competitive or self-dealing behaviors, such as paying its affiliated providers or subcontractors more than others, DHHS will include a clause in the RFP forbidding such actions.



PHPs will also be required to cover out-of-network services for enrollees. If the provider refuses to contract with the PHP or fails to meet quality standards, the PHP prohibited from reimbursing the provider more than 90 percent of the Medicaid fee-for-service rate for services.

[Prepaid Health Plans in North Carolina Medicaid Managed Care Policy Paper](#)



HMA MEDICAID ROUNDUP

Florida

Florida to Move Ahead With Cuts to Correctional Treatment, Transitional Programs. *The Miami Herald* reported on May 25, 2018, that Florida rejected appeals to stop \$28 million in cuts to correctional treatment and transitional programs aimed at preventing individuals from becoming repeat offenders. The state will lay off employees at inmate transition and treatment programs, with the savings going to help fund the renewal of a prison health care contract with Centurion. Providers, employers, and families of inmates have voiced strong opposition to the cuts. [Read More](#)

Illinois

BCBS-Illinois to Cut Medicaid Reimbursement Rates for DME Suppliers. *Crain's Chicago Business* reported on May 24, 2018, that Blue Cross & Blue Shield of Illinois plans to cut Medicaid reimbursement rates by an estimated 35 percent for suppliers of durable medical equipment, effective January 1, 2019. As previously reported, Illinois last month froze enrollment in BCBS-IL Medicaid plans in certain regions of the state, citing an inadequate Medicaid managed care provider network and failure to respond to grievances and appeals. [Read More](#)

Kansas

Medicaid Vendor Expects to Meet June 1 Performance Targets. *The Wichita Eagle* reported on May 24, 2018, that Maximus expects to meet a June 1 deadline to address Kansas' Medicaid applications backlog and improve the accuracy of financial payments. The company could face fines if it falls short. Kansas Medicaid Director Jon Hamdorf said Maximus has "really made a good faith effort" toward improving performance. [Read More](#)

Kentucky

Kentucky to Partner with Foundation to Implement Medicaid Work Requirements, Premiums. *The Associated Press* reported on May 30, 2018, that Kentucky Governor Matt Bevin will announce a partnership with the Foundation for a Healthy Kentucky to assist in the implementation of Medicaid work requirements and premiums. The state requested a waiver to implement the changes, which was approved by the Trump administration. [Read More](#)

Maine

Judge Considers Ordering LePage Administration to Expand Medicaid. *Modern Healthcare* reported on May 24, 2018, that Kennebec County Superior Court Justice Michaela Murphy will decide whether to order Maine to implement a voter-approved expansion of Medicaid. During opening arguments in a lawsuit brought by healthcare advocates, Murphy said Maine Governor Paul LePage has a “duty to enforce” the voter-passed law. LePage has refused to implement expansion, citing funding concerns. Expansion, which is slated to start July 2, would cover an estimated 70,000 Maine residents. [Read More](#)

Minnesota

Minnesota Seeks Waiver to Use Medicaid Funding for Residential Drug Treatment. *The Star Tribune* reported on May 24, 2018, that Minnesota is seeking a waiver to use Medicaid funding for residential drug treatment, which is currently prohibited in residential centers with more than 16 beds. The waiver is part of a state effort to treat addiction and includes opioid treatment as well as expanded Medicaid benefits for community-based services. Minnesota officials expect to receive approval from the Centers for Medicare & Medicaid Services by July 1. [Read More](#)

New York

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

New York Health Home Initiatives Enacted. As part of its fiscal year 2018-19 budget, New York enacted several incentives in support of its health home program. Beginning April 1, 2018, New York has established a Health Home Healthy Rewards program. The program, which will be administered by Medicaid managed care plans, is designed to promote wellness through proactive access to preventive care, helping members stay engaged in Health Home care management, and as a result, derive Medicaid savings from the reduction of preventable emergency visits and preventable inpatient hospital stays. Health Home members will be rewarded for participating in wellness activities, including but not limited to:

- Annual physicals
- Maintaining a healthy body mass index (BMI)
- Smoking cessation activities
- Continuous enrollment in Health Home

The budget also included an initiative to enroll high-risk Medicaid beneficiaries into health homes. The initiative is designed to ensure high-risk, high-need, high-cost Medicaid members are enrolled in health homes and receive comprehensive care management. Under the initiative, Medicaid managed care plans will be assessed financial penalties when high-risk enrollees are not enrolled in health homes at target percentages. The rates of penalty will be structured in a tiered manner, i.e., the further away managed care plans and health homes are from the target the larger the penalty. Up to 50 percent of the penalty can be passed on to the health home. [Read More](#)

Department of Health Launches NYS Health Connector. The New York State Department of Health launched the NYS Health Connector, a web-based application that allows quick access to a wide range of health information. Three dashboards are currently posted providing data on suicides, hospital volume and cost data for three conditions (cardiac procedures, newborns/deliveries, and joint replacement surgeries), and emergency department visits. The site will also provide access to the All Payer Data Base (APD). New York enacted legislation in 2011 that allowed for the creation of an APD to provide a more complete and accurate picture of the health care delivery system across public and private payers and to improve population health. Once fully developed, the APD will house data from public and private insurance payers, including insurance carriers, health plans, third-party administrators, and pharmacy benefit managers, as well as Medicaid and Medicare. Eventually, the APD will add other health related data that includes functional assessments, surveys, public health registries, social determinants of health, and clinical data from electronic health records. [Read More](#)

New York Health + Hospitals Releases Executive Budget. NY Health + Hospitals CEO Dr. Mitchell Katz presented the public hospital system's executive budget at a City Council budget hearing on May 24, 2018. He outlined some of the major challenges the 11-hospital system is facing, including long wait times, the inability to function as a truly integrated health system, and lack of a modern IT and financial infrastructure. Katz noted the financial progress the system has made, stating that H+H will have achieved over \$600 million in revenue generating initiatives. He also noted the delay in federal Disproportionate Share Hospital payment cuts provide H+H with \$700 million in additional revenue. He then reviewed the seven-point plan his administration has developed to address on-going financial challenges. Through the plan, H+H will:

- Reduce administrative expenses by eliminating consultants and decreasing administrative positions;
- Bill insurance for insured patients;
- Code and document effectively;
- Stop sending away paying patients;
- Invest resources into hiring positions that are revenue generating;
- Start providing those specialized services that are well reimbursed;
- Convert uninsured people who qualify for insurance to be insured. [Read More](#)

Ohio

Providers Ask State to Delay Transition to Managed Care for Medicaid Behavioral Health. *The Columbus Dispatch* reported on May 28, 2018, that the Ohio Council of Behavioral Health & Family Services Providers, representing about 150 providers, requested that the Ohio Department of Medicaid delay a planned July 1, 2018, transition of Medicaid behavioral health into managed care. The request for a six-to-seven-month postponement argues that many providers will not be prepared to accommodate changes to billing and reimbursement. However, the state does not plan to delay the transition. [Read More](#)

Ohio Providers Are Concerned Over Transition of Mental Health, Addiction Services to Managed Care. *WOSU Radio* reported on May 29, 2018, that Ohio is moving forward with transitioning Medicaid mental health and addiction services from fee-for-service to managed care by July 1, despite concerns from providers regarding timeliness of payments. Senator Dave Burke (R-Marysville) stated that the redesign was on schedule, including reducing payments for some services and increasing pay for others. [Read More](#)

South Dakota

South Dakota Proposes Medicaid Work Requirements in 2 Counties, Addresses 'Subsidy Cliff'. *Modern Healthcare* reported on May 23, 2018, that South Dakota has proposed a pilot Medicaid work requirement program in Minnehaha and Pennington counties as well as an initiative to address the "subsidy cliff" when enrollees begin to earn too much to qualify for Medicaid. Under the draft waiver proposal released by the state, beneficiaries ages 19 to 59 would be required to work, search for work, or engage in job training at least 80 hours a month. Pregnant women and parents of dependent children under one year old would be exempt. Individuals who lose Medicaid eligibility but do not make enough to qualify for subsidies on the Exchange would be eligible for an initiative called Career Connector, which would provide coverage assistance until individuals reach 150 percent of the federal poverty level. At that point, they would be eligible for Exchange subsidies. [Read More](#)

Utah

Utah to Vote on Medicaid Expansion Ballot Measure in November. The *Washington Examiner* reported on May 29, 2018, that Utah has officially placed Medicaid expansion on the November ballot after an advocacy group gathered the required signatures. Utah would become the 34th state to implement the expansion if the measure passes. [Read More](#)

Hospital System Drops Out of Molina Medicaid, CHIP Networks for Non-Emergency Services. *Deseret News* reported on May 23, 2018, that the University of Utah Health System has dropped out of Molina Healthcare's networks for non-emergency Medicaid and Children's Health Insurance Program (CHIP) services. The health system cited administrative problems, including claims denials and payment delays. Molina has about 71,000 Medicaid and 7,700 CHIP members in the state. [Read More](#)

Virginia

Virginia Senate Approves Medicaid Expansion. *The Hill* reported on May 30, 2018, that the Virginia Senate approved Medicaid expansion legislation in a 23-17 vote. The expansion was included in a budget bill, which is expected to pass the House and move onto Democratic Governor Ralph Northam for his signature. Virginia is also expected to submit a waiver asking federal regulators to approve Medicaid work requirements for beneficiaries above the poverty level. [Read More](#)

Washington

Washington Announces Integrated Medicaid Managed Care Bid Winners. The Washington Health Care Authority announced on May 24, 2018, the successful bidders of the state's integrated Medicaid managed care procurement: Amerigroup/Anthem, Community Health Plan of Washington, Centene/Coordinated Care of Washington, Molina, and UnitedHealthcare. The Integrated Managed Care contracts are effective 2019-20, with two, one-year extension options and cover 1.6 million Medicaid members in the state's 10 Regional Service Areas (RSAs). [Read More](#)

National

America's Physician Groups Submits Direct Provider Contracting Proposal to CMS. *Modern Healthcare* reported on May 25, 2018, that America's Physician Groups (formerly CAPG) has submitted its suggestions for how federal regulators could structure a direct provider contracting (DPC) model for Medicare payments. The proposal, submitted in response to a Centers for Medicare & Medicaid Services (CMS) request for input, calls for provider networks to receive pre-paid Medicare funds to manage patient care. CMS would set capitation rates for the program, which would be voluntary for Medicare beneficiaries. [Read More](#)

CMS Network Adequacy Exemption Proposal Could Hurt Providers. *Modern Healthcare* reported on May 23, 2018, that a federal proposal to exempt states from certain network adequacy assessment requirements could hurt providers. The proposal by the Centers for Medicare & Medicaid Services (CMS) would allow states to cut Medicaid rates by up to 4 percent without conducting a network adequacy assessment. CMS estimates that 17 states would be exempt from access monitoring requirements if the exemption takes effect. [Read More](#)



INDUSTRY NEWS

WellCare Health Plans to Acquire Meridian for \$2.5 Billion. On May 29, 2018, WellCare Health Plans, Inc., announced a definitive agreement to acquire Meridian in a deal valued at \$2.5 billion in cash and stock. Meridian consists of Meridian Health Plan of Michigan, Meridian Health Plan of Illinois, and MeridianRx, a pharmacy benefit manager. The transaction is expected to close by the end of 2018. As of May 1, Meridian had an estimated 508,000 Medicaid members in Michigan and 565,000 in Illinois. [Read More](#)

Molina Names Thomas Tran CFO. Molina Healthcare, Inc. announced the appointment of Thomas Tran as chief financial officer (CFO), replacing Joseph White, who is retiring effective June 4, 2018. Tran was most recently with Sentry Data Systems and also served as CFO of WellCare Health Plans, Inc. [Read More](#)

COMPANY ANNOUNCEMENTS

Magellan Health Elects Two New Board Members. [Read more](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Spring/Summer 2018	North Carolina	RFP Release	1,500,000
May 2018	Arizona I/DD Integrated Health Care Choice	RFP Release	~30,000
May 30, 2018	New Hampshire	RFP Release	160,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 7, 2018	Alabama ICN (MLTSS)	Proposals Due	25,000
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
July 1, 2018	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 11, 2018	Alabama ICN (MLTSS)	Contract Award	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Implementation	~30,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA WELCOMES

Margaret Williams, Principal - Denver, CO

Margaret Williams joins HMA most recently from Care1st Health Plan / Blue Shield California where she served as associate vice president quality improvement. In this role, Margaret oversaw the clinical quality, facility site review, credentialing, initial health assessments, maternity case finding, provider preventable conditions, appeals and grievances, utilization management delegation oversight, claims oversight and NCQA readiness. She integrated knowledge of various regulatory requirements from the California Department of Managed Health Care (DMHC), CMS, LA Care, and Medi-Cal and directed leadership to deliver high audit scores and 100 percent compliance. She developed and made/recommended changes to the yearly quality improvement (QI) plan to assure quality care and continued compliance with all regulatory requirements. Margaret implemented departmental policy and procedures to meet NCQA and state requirements and generated custom reports shown to adequately evaluate quality of care. She also planned and implemented annual department budgets, analyzed staffing requirements and made recommendations for staffing allocations, and supervised the evaluation of all QI Department personnel.

Prior to joining Care1st Health Plan, Margaret worked for UnitedHealthcare where she served as clinical quality consultant for Las Vegas markets, director of quality management, and manager of quality management. As consultant, Margaret reviewed potential risk/quality of care issues, reviewed processes and regulatory requirements, and consulted with the medical and legal peer review committees. She served as an expert witness in fair hearings related to the company's quality review process and physician peer review process, and assisted corporate and outside legal counsel. As director, Margaret provided oversight of the peer review process for the plan and medical group practice and resolved grievances for commercial and government programs. She directed staff in quality and risk activities, including investigation and review of medical records and resolution of patient complaints and grievances and liaised a managed care company to the Professional Review Organization. As manager, she served as a committee member for United's subsidiaries and medical group practice representing the Quality Management Department. She also managed the nursing and support staff in the investigative medical record review of inpatient and outpatient care and resolution of patient complaints.

Margaret earned her bachelor's degree in healthcare management from the University of St. Francis. She received her associate's degree in nursing from Shawnee State University. She is a licensed registered nurse.

HMA NEWS

Upcoming Webinar - Partnership Opportunities for Payers, Providers and States: Supportive Housing for High Utilizers on June 7, 1-2 EDT. [Read More](#)

NEW THIS WEEK ON HMA INFORMATION SERVICES (HMAIS):

Medicaid Data and Updates:

- MLRs Average 89.3% at Texas Medicaid MCOs, 2017 Data
- MLRs Average 82.2% at Tennessee Medicaid MCOs, 2017 Data
- MLRs Average 90.7% at Rhode Island Medicaid MCOs, 2017 Data
- MLRs Average 88.0% at Florida MMA MCOs, 2017 Data
- MLRs Average 87.7% at New Jersey Medicaid MCOs, 2017 Data
- MLRs Average 91.6% Among Nebraska Medicaid MCOs, 2017 Data
- Ohio Medicaid Managed Care Enrollment is Down 3.5%, Apr-18 Data
- Ohio Dual Demo Enrollment is Down 0.5%, May-18 Data
- Kentucky Medicaid Managed Care Enrollment is Flat, Feb-18 Data
- Minnesota Medicaid Managed Care Enrollment is Up 1.4%, May-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arizona Major Decision: Division of Developmental Disabilities Integrated Health Care Choice Plans Request for Proposal, May-18
- Missouri Third Party Liability Services RFI, May-18
- Washington 2019/2020 Integrated Managed Care (IMC) RFP and Award, 2018

Medicaid Program Reports and Updates:

- Arizona Medicaid Annual Reports, 2014-17
- Washington Medicaid Managed Care Regional Analysis HEDIS Reports, 2015-17
- Washington Medicaid Managed Care Comparative Analysis HEDIS Reports, 2013-17
- Washington Medicaid Managed Care External Quality Review Reports, 2012-17

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- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

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