
COMPREHENSIVE
MEDICARE
SOLUTIONS
HMA
HEALTH
MANAGEMENT
ASSOCIATES


Unparalleled
insights
for what's
ahead

COMPREHENSIVE MEDICARE SERVICES, TEAM OF EXPERTS

HMA's team of expert Medicare consultants has vast and diverse expertise to help clients navigate and succeed in the ever-changing Medicare landscape. Our specialists apply their deep business, analytic, clinical, and policy expertise into unparalleled insights and knowledge that help clients solve their greatest Medicare challenges.

Medicare is the nation's single largest health program and has undergone rapid change with millions of new beneficiaries enrolling in private managed care plans, including those eligible for Medicaid benefits. Enrollment growth, budget pressures, new political directions, and rapid technological change will continue to shape the program's future.

As new payment and delivery system innovations emerge, impacting health plans, delivery systems, technology companies, and providers' business models, trusted guidance to navigate these new challenges and opportunities is more important than ever.

Our experts understand the entirety of the Medicare program and help clients with complex business issues in both the traditional Medicare fee-for-service programs and Medicare Advantage.

We work side-by-side with leaders of health plans, including Medicare Advantage plans, start-ups, provider-sponsored plans, delivery systems, technology companies, state and local governments, research foundations, and advocacy organizations to develop successful strategies amid shifting policies and priorities.

In addition to advising C-suite and organizational leaders, our consultants also serve as interim plan leadership to assist start-ups or transition business environments. With more than 20 offices across the country, our experts are ready to provide you with insightful, innovative, and expert Medicare support.

OUR TEAM

From working with the Medicare program at the federal level to the front lines, our Medicare team's comprehensive knowledge spans all aspects of this complex and evolving program. Our Medicare colleagues have established and implemented federal policy, led health plan strategy and operations, and developed payment and delivery innovations, now recognized as industry best practices.

HMA's Medicare experts are among the most sought-after advisors in the country and have served as former health plan executives, authorities on federal and state policy, payment experts, data analysts, and physician leaders. Their diverse backgrounds offer a wealth of real-world experience to help clients address some of their most pressing needs.

Policy Thought Leadership.

Our team can review and analyze Medicare beneficiary needs, spending, benefit innovations, and medical utilization trends as well as identify insights to influence and shape the future of Medicare policy development and implementation.

Medicare Advantage Strategies.

Through comprehensive market expansion assessments, feasibility studies, competitive analysis, and growth strategies, we can support your organization by:

+ Conducting comprehensive reviews of Medicare Star strategy and risk adjustment processes.
+ Developing Special-Needs Plans' Models of Care, state Medicaid agency strategies, and complex care management.
+ Providing CMS program audit support, including corrective action plan development and implementation.

Medicare Analytics.

We have developed industry-leading data analytics to help a wide-range of clients gain new insights into their program operations and improve strategies by:

+ Examining revenue streams to improve efficiencies and value
+ Analyzing the impact of new federal legislative and regulatory proposals
+ Developing network and provider contracting strategies, including the design of alternative payment models

Michael Engelhard, MBA

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An accomplished health plan executive, Michael Engelhard has more than 30 years of experience. His expertise includes organizational leadership, strategy and strategic planning, financial analysis and modeling, rate setting, Medi-Cal and Medicare program design and expertise, and program compliance.

A skilled leader, he has directed an array of projects, including strategic planning and delivery system redesign for multiple California-based health plans. He has also worked with provider group and clinic system strategy development where he advised provider groups about program policy and reimbursement and supporting Programs of All-inclusive Care for the Elderly (PACE) organizations.

Prior to HMA, Michael served as chief executive officer of Gold Coast Health Plan and chief financial officer at CalOptima, both California managed care plans.

Michael has been responsible for financial support of Dual Eligible Special Needs Plans operations including bid development, encounters reporting; and leadership for Medicare strategic planning, successful application for the Medicare-Medicaid Pilot for dual eligible members and launching a PACE organization.

Previously, Michael worked at Health Net, Inc., as vice president and regional finance officer for the company's senior products division. He was responsible for establishing all financial and accounting operations for the Part D product, approving Part D bids, the plan's encounters activities and management reporting for all Medicare Advantage operations across five states.

Michael earned his Master of Business Administration degree with a concentration in finance from Columbia Business School in New York City. He received his bachelor's degree in nuclear engineering from University of California at Santa Barbara.

Margaret Tatar, JD

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Margaret Tatar has more than 25 years of public and private sector experience in managed care program and policy development, health policy, program development, advocacy, and government and legislative affairs.

She has a strong track record in managed care plan leadership, leading large-scale managed care initiatives and multi-disciplinary teams in complex operating environments while fostering professional development and mentoring staff. She has served in the federal government's Health Care Financing Administration (HCFA), the executive and legislative branches in Colorado and California, and a key leadership position with CalOptima, a large public health plan in California.

In her most recent position as acting deputy director of delivery systems in California's Department of Health Care Services (DHCS), she was responsible for the network of 23 contracted health plans that deliver healthcare services to over 9 million Californians. She was also responsible for the Long-Term Care Division and California's Children Services program. During her tenure at DHCS, she oversaw a significant expansion of managed care as the primary delivery system for California's Medicaid program (Medi-Cal). She also served as the operational lead for the design, development, and implementation of California's Medicare-Medicaid Plan program.

Margaret has launched Programs of All-Inclusive Care for the Elderly and Dual Eligible Special Needs Plans giving her direct operational experience as well as policy expertise in Medicare.

Margaret earned her undergraduate degree in Latin at Bryn Mawr College in Bryn Mawr, Pennsylvania, and her law degree at Villanova University School of Law in Villanova, Pennsylvania.

Sarah Barth, JD

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Sarah Barth, JD, is a health policy leader with extensive experience leading Medicare-Medicaid integration initiatives. She works with health plans, states, federal commissions and philanthropic foundations on policy requirements, program trends, and market strategy for integrated Medicare-Medicaid managed care models and Medicaid managed long-term services and supports (LTSS) programs.

Her operational expertise includes program oversight, care coordination, communication plans and stakeholder engagement with Medicare-Medicaid stakeholders.

Sarah previously served as the director of integrated care and long-term services at the Center for Health Care Strategies (CHCS). While there, she was the project director for a consortium of high-performing healthcare organizations identifying and testing innovative strategies to enhance and integrate care for high-cost, high-need populations. She also led a project providing technical assistance to 10 states transforming from LTSS systems to managed care delivery and promoting community-based living.

Sarah has over 16 years of state regulatory experience. At Massachusetts Medicaid, she developed legislative and media strategies, oversaw large interagency projects, including implementation of Medicare Part D, and contributed to state healthcare reform initiatives. She served as bureau chief for LTSS at the New Mexico Medical Assistance Division where she developed and oversaw the implementation of the state's mandatory Medicaid managed long-term services and supports program which included coverage for Medicare-Medicaid dual eligible individuals.

Sarah has published extensively on Medicare-Medicaid integration initiatives and is a veteran facilitator of diverse stakeholders with divergent views, helping them reach consensus on complex topics.

She has a law degree from Suffolk University Law School and a bachelor's degree from the University of Pennsylvania.

Trudi Carter, MD

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Dr. Trudi Carter is deeply commited to her work and putting the welfare of patients first. For more than 30 years, she has worked in medical affairs and healthcare administration.

As chief medical officer (CMO) at Los Angeles Care Health Plan, the largest public health plan in the nation, Dr. Carter implemented strategies to ensure quality healthcare to L.A. Care's two million members. She oversaw health services operations and focused on enhancing access and quality of care, especially for seniors and special needs populations.

With a strong background and understanding of Centers for Medicare and Medicaid Services (CMS) audit protocols and processes, she developed strategies for improving CMS Star Ratings. She also has significant experience with individual products, as well as the integration and management of services across multiples lines of business, including Medi-Cal, Managed Medicare, Medicare D-SNP, and commercial.

Prior to L.A. Care, Dr. Carter was CMO at CalOptima, where, in addition to her traditional CMO responsibilities, she led quality efforts that resulted in achieving four-star performance for the CalOptima special needs plan, top quality performance for the CalOptima Medi-Cal plan and outstanding quality performance for the Healthy Families program.

Dr. Carter also had positions with Catholic Healthcare West, a hospital chain in California, and Schaller Anderson, a National Medicaid and MedPartners Practice Management company. Additionally, she practiced for 12 years as a board-certified pediatrician at Hawthorne Community Medical Group.

Dr. Carter earned her MD at Johns Hopkins Medical School and completed her internship and residency in pediatrics at Pittsburgh Children's Hospital. She received her bachelor's degree from Howard University.

Julie Faulhaber

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A nationally recognized leader in Medicare, special needs plan (SNP), Dual Demonstration and Medicaid programs and policies, Julie Faulhaber is an experienced strategic and mission-driven leader with more than 25 years of healthcare policy experience.

Julie has a sustained pattern of managing profitable product portfolios and a demonstrated expertise in business and product development, product implementation and management, change management, government relations and compliance. Her work has included leadership and oversight of multi-state SNP and Medicaid business, care coordination, government relations and overseeing the Centers for Medicare and Medicaid Services (CMS) bidding process for SNP and dual eligible products.

Before joining HMA, Julie served with Health Care Service Corporation (HCSC) where she was vice president of Enterprise Medicaid and interim vice president of Illinois Medicaid and Medica Health Plans in Minnesota where she was vice president and general manager of state public programs.

While serving at Medica Health Plan, she received an innovation award from the state Medicaid agency for developing and implementing a program to integrate physical and behavioral healthcare. Julie also led its Medicare Cost Plan business, successful CMS audits, increased enrollment, exceeded budget and program goals and engaged stakeholders to retool programs to include those with disabilities.

Julie earned a bachelor's degree in philosophy from Creighton University and a Master of Business Administration from the University of Wisconsin, Milwaukee.

Zach Gaumer

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Zach Gaumer is an accomplished analyst and project manager with nearly 20 years of health policy experience and a deep understanding of Medicare, healthcare payment systems, healthcare datasets, research methods and policy reform efforts.

Prior to joining HMA, Zach was a principal policy analyst at the Medicare Payment Advisory Commission (MedPAC). During his tenure at MedPAC, Zach was an expert advisor to U.S. Congressional committee staff on several Medicare payment systems and topics.

Zach is an expert on hospital payment policy, including Medicare's inpatient and outpatient payment systems, many non-Medicare hospital payment systems, and recent industry-wide developments. In addition to hospital payment systems, he has experience working with Medicare's physician fee schedule and ambulance fee schedule. His expertise also includes telehealth, special payments for new drugs and technologies, special payments for rural hospitals, ambulatory surgical centers, urgent care centers, electronic health records systems, quality measurement, bundled payment, global budgeting, and value-based payment models. His work at MedPAC also exposed him to policy areas including post-acute care, Medicare Advantage, hospice, and end-stage renal disease.

Earlier in his career, Zach served in the U.S. Government Accountability Office, where he conducted health policy research and produced reports related to the Medicare Advantage program, Accountable Care Organizations, Medicare's end-stage renal disease program and specialty hospitals.

Zach has a bachelor's degree from Kenyon College and a Master of Political Studies from Johns Hopkins University with concentrations in health policy and international affairs.

Deborah Gracey

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Deborah Gracey has extensive experience leading large-scale delivery system transformation and supporting financial mechanisms. Her experience with Medicare includes serving as president of Humana's Medicare business for the Great Lakes region where she was responsible for the profitability and growth of a $1.2 billion business with 35 Medicare Advantage plans in Illinois, Michigan, and Wisconsin.

She is a strategic and innovative leader with experience spearheading large-scale transformation and growth efforts as well as connecting the payer and the provider through her expertise. She has expertise in healthcare finance, alternative payment models, Medicare, Medicaid, dual eligible models, delivery system integration, and provider strategies for success with managed care and value-based payment structures.

Deborah has deep knowledge of Maryland's All-Payer Model and played a key role in the development of the state's 10-year transformation plan, the Care Redesign Amendment, and two of the initial programs created to align physicians with hospitals, upgrade the care of high- and rising-risk Medicare patients, and offer the potential for hospital incentive payments to physicians to support the transformation.

Deborah is certified as a Six Sigma Green Belt. She earned her bachelor's degree in business administration from the University of Maryland University College. She has also completed an intensive 16-month program, "Healthcare Leaders 2020."

Eric Hammelman

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Eric Hammelman is a data-driven analyst who has spent his career overseeing healthcare data, risk adjustment, and data analytics teams and projects leader in translating complex data analytics into actionable business strategies for healthcare entities, Eric has directed teams to conduct data-driven analyses of the impact of payment policies on healthcare patterns, including the effects of emerging payment and delivery models on providers, manufacturers and health plans.

Most recently, Eric led a risk adjustment analytics team for Medicare, Medicaid and Affordable Care Act business lines. During his tenure, the team identified and implemented several new processes to expand the risk adjustment operations by more efficiently engaging members and physicians. He also spearheaded efforts to combine claims, clinical and other non-traditional data to create a comprehensive risk profile of enrollees and providers.

Eric has experience analyzing large data sets including Medicare, Medicaid and private payer claims to identify trends and patterns ¬¬– and then forecasting those trends to estimate future impact. He has also developed user-friendly models in Excel to estimate premiums, medical cost and coverage implications for a variety of state and federal proposals. Earlier in his career, he provided investment advice to institutional investors about companies in the healthcare services sector.

Eric earned a Master of Business Administration from the University of Southern California, Marshall School of Business, a Master of Music Performance from Mannes College of Music, and a bachelor's degree from the University of Illinois at Urbana-Champaign. He is a Chartered Financial Analyst (CFA) Charterholder.

Julie Johnston, MPH

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Julie Johnston has more than 25 years of senior level experience working on the design, implementation, and operations of innovative publicly financed managed care programs.

Julie has expertise in new market and product expansions, business development strategies, procurement support, managed care implementations and operations, and the development of innovative programs and solutions for complex populations.

Her work at HMA includes assisting managed care clients with market analysis and feasibility studies and the development of programs, strategies and models of care that address the unique needs of Medicare, Medicaid and dual-eligible individuals.

Prior to joining HMA, Julie held a variety of senior executive positions with UnitedHealthcare, focused on government-sponsored Medicare and Medicaid programs. Julie specialized in the development and adoption of managed long-term services and supports (MLTSS) programs and integrated Medicare and Medicaid delivery models serving the elderly, persons with disabilities and dual eligibles. She successfully led business development efforts and executed growth strategies which resulted in the implementation of several MLTSS programs and dual integration initiatives across multiple markets.

She also led start-up efforts for a statewide safety-net owned Medicaid, State Children's Health Insurance Program, and managed behavioral health plan where she was responsible for the development and management of member and provider services, enrollment and eligibility, member education, and care coordination functions.

Julie has a Master of Public Health from the University of North Carolina-Chapel Hill and a bachelor's degree from the University of California, San Diego.

Linda Lee, MPH

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With a proven track record of increasing quality metrics and improving Medicare Star Ratings and more than 20 years of experience in the managed care industry, Linda Lee ensures operational alignment for health plans – increasing efficiency and compliance while integrating regulatory requirements into day-to-day operations. Her work at HMA focuses on Medicare and Medicaid products, quality improvement, and managed care operational assessments. Linda has evaluated DSNP Models of Care, helped health plans submit Medicare applications, and led efforts to improve quality outcomes and risk adjustment.

Linda previously served as senior director of Medicare performance management at L.A. Care Health Plan, where she successfully led efforts to improve its Star Ratings. She also headed up an enterprise-wide program to evaluate and improve Medicare Part C and D star measures.

With extensive knowledge of health plan clinical operations, Linda developed and implemented an integrated Medicare model of care that incorporated industry best practice care management models to improve member engagement and health outcomes. She oversaw product operations and strategic planning in the areas of Medicare Advantage applications, risk adjustment programs, and rapid cycle improvement projects for a Medicare-Medicaid Plan (MMP), including reducing potentially avoidable events, improving long-term care claims timeliness, and reducing readmissions.

Prior to joining L.A. Care, Linda was the director of medical data management at CalOptima.

Linda earned her Master of Public Health degree in community health sciences and her bachelor's degree in molecular biology from UCLA.

Tom Murar

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An accomplished health plan leader and former Medicare chief financial officer, Tom Murar offers a valuable perspective in this changing healthcare landscape.

Tom served as CFO for Consumers Mutual Insurance of Michigan CO-OP, a nonprofit health insurer licensed as a mutual insurance company, and as CFO for other Medicaid health plans. While at Consumers Mutual he played a key role in the company's inception, incorporation, and operation. As the CFO, he oversaw procedures for financial reporting and administration, purchasing and risk management and produced financial analyses. He was involved in the Qualified Health Plan process for health insurance exchange products, including plan design, financial modeling, coordination of actuarial work, filing of templates, and the Department of Insurance and Financial Services approval process.

Prior to his work with Consumers Mutual, Tom was vice president of Medicare/Medicaid Solutions for Altegra Health (formerly Dynamic Commerce Applications) where he was responsible for identifying potential clients, negotiating and implementing contracts, developing results-orientated solutions, and helping clients develop and implement operational programs needed to succeed in a risk adjustment environment.

During his career Tom also has served as a senior financial analyst for health plans and a large health system.

Tom received his Master of Business Administration degree from the University of Notre Dame and his bachelor's degree from the University of Detroit.

Don Novo

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A seasoned health policy professional with more than 20 years' experience in publicly funded healthcare, Don Novo is an expert in Medicare and Medicaid program administration.

A former leader with the Centers for Medicare and Medicaid Services (CMS), he worked on health reform implementation projects related to establishing both federal and state-based marketplaces. He is also a seasoned facilitator, helping states obtain licensure to operate their Medicare lines of business.

Don has a deep understanding of and experience working with both Medicare and Medicaid and is an expert in navigating regulatory policy for dual eligible members. He has led such efforts in leadership positions at both the state and federal levels, and his work includes both direct state Medicaid program administration and federal regulatory oversight.

He helps guide and inform clients about the development of Medicaid waiver programs, implementation of new delivery system models, and program expansions. His work has allowed health plans and associations to develop programs that improve the quality of care while reducing cost and maximizing federal revenue opportunities. He also advises technology clients of opportunities and provides business strategy within the publicly financed healthcare market.

Prior to his work with CMS, Don served as the director of member policy implementation and evaluation services with MassHealth, the Massachusetts Medicaid agency. In this role, he focused efforts on dual eligible populations as the state expanded eligibility within their Programs of All-Inclusive Care for the Elderly and the development and implementation of the state's Senior Care Options (SCO) program. The SCO was later developed into the national model for dual eligible seniors for Medicare and Medicaid alignment programs.

Don received his bachelor's degree from the University of Bridgeport.

Sarah M. Owens

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A diligent and forward-thinking leader with expertise in managed accountable care and operations that bridges health plan and provider sides of business, Sarah M. Owens is an accomplished and compassionate healthcare leader.

Her work has focused on Medicare, Dual Special Needs Plans (D-SNP), Medicare-Medicaid, Fully Integrated Dual Eligibles, and Managed Long-Term Services and Supports. She is a skilled collaborator, partnering with physicians, healthcare executives, and cross-functional teams to tackle complex problems, identify solutions, and implement best practices.

Before joining HMA, Sarah served in an executive leadership role with AmeriHealth Caritas where she directed all Medicare operations and had profit and loss accountability for three Medicare markets, operating a D-SNP and two Medicare Medicaid Plans (MMP). As a leader, Sarah focused on fostering an environment of trust, inclusiveness and accountability while setting high performance standards and measurements. She also focused on growth, compliance, Stars, Model of Care development, flawless execution, appropriate risk adjustment, and improved financial performance.

Serving in a variety of other health plan and health system leadership roles, her work experience includes creating strategy and program design for D-SNPs, developing staff and operations for a provider-sponsored Medicare Advantage plan, which earned a 4.5 Centers for Medicare & Medicaid Services (CMS) Star rating, forming a management services organization for a hospital system, and designing a managed care strategy for a complex hospital system which included medical and psychiatric services and nursing care.

Sarah earned a bachelor's degree from the University of New York at Albany and completed Management Training for Health Management Organization Executives at the Rensselaer Polytechnic Institute in Troy, NY.

Jose Robles

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Jose Robles brings more than 24 years of experience serving healthcare systems and multi-discipline organizations to HMA. He has worked extensively in the Medicare reimbursement and regulatory environment.

He possesses strong technical skills and the leadership skills required to develop strategic plans, policies, and procedures for health systems — from academic medical centers to community hospitals.

Prior to joining HMA, Jose was a director at PricewaterhouseCoopers, a large public accounting firm, where he served as a healthcare consultant to large public and private clients. In this role, he led various projects where he specialized in Medicare cost reporting, indirect medical education/Graduate Medical Education payments, wage index reporting, and regulatory impact analysis.

Jose also has experience obtaining various provider payment and facility specific Medicare designations. He also understands the rules related to provider-based status and various programs such as the 340B Drug Program.

Jose is a Certified Public Accountant (inactive) and has vast experience working with health system chief financial officers and the financial statement of an organization. Specifically, he has assisted in valuing patient accounts receivable, amounts due from government payers, and various other due-diligence related activities.

He has a bachelor's degree in accountancy from the University of Illinois, and is a member of the Healthcare Financial Management Association and the Association of Latino Professionals in Finance and Accounting.

Madeleine (Maddy) Shea, PhD

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Throughout her career, Maddy Shea has worked to accelerate progress on health improvement goals. She has provided leadership on collective action at the federal, state and local levels and has a unique, cross-sectoral perspective on strategies to improve Medicare access, quality and outcomes.

At the Centers for Medicare & Medicaid Services (CMS), Maddy led the development, implementation and evaluation of the CMS Equity Plan for Improving Quality in Medicare.

She has developed Medicare Advantage reports, web-based Medicare fee-for-service county and state maps, a guide to reducing disparities in Medicare readmissions, resources to increase the cultural and linguistic appropriateness of care, and tools to improve access to care for people with physical disabilities.

Maddy is an expert in Medicare performance measurement, particularly for high-need beneficiaries and advised CMS leadership on the Medicare Diabetes Prevention Program, the Accountable Health Community Model and the Transforming Clinical Practice Initiative. She also co-led strategic planning to respond to the opioid epidemic and to improve care in rural areas.

As the first director of Maryland's Office of Population Health Improvement, Maddy developed the framework to guide healthcare transformation in Maryland, and the performance measures are now part of the state's Medicare waiver program. In Baltimore, she developed the first U.S. city healthy homes division to reduce asthma, injury, and malnutrition in low-income minority communities.

Maddy earned her PhD in public policy from the University of Maryland Baltimore County, her master's degree in management from Johns Hopkins University, and her bachelor's degree in economics from Trinity College in Washington.

Aimee Lashbrook, JD, MHSA

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Aimee Lashbrook specializes in government programs, policy research and analysis, new business strategy, and program implementation. She has in-depth understanding of Medicare Advantage policy and guidance and additional expertise in Medicaid, traditional Medicare, federal payment reforms and pharmacy. Her strategic thinking, research and writing skills quickly turn complex issues into actionable opportunities.

Aimee joined HMA from a large Blue Cross Blue Shield plan where she managed the analysis of federal and state policy for its Medicaid and Medicare lines of business. Her analysis informed enterprise strategy, drove business decisions, and supported implementation plans during a period of rapid change.

Each year she led the plan through the Medicare Advantage Draft Call Letter process and proposed rule changes to identify impacts and opportunities, enhance operational readiness and business strategy, and submit feedback to the Centers for Medicare and Medicaid Services (CMS). Focus areas included changes in Star Ratings, risk adjustment, benefits flexibility, Alternative Payment Models, and Part D.

Aimee works closely with clients to promote their business strategy in a complex regulatory environment. She also performs research on a variety of relevant healthcare topics, manages readiness reviews, performs operational assessments, and assists health plans with government applications.

Aimee earned her master's degree in health services administration from the University of Michigan School of Public Health and her law degree and certificate of health law from the Loyola University Chicago School of Law. She earned her bachelor's degree in political science and English from Albion College in Michigan.

Danielle Pavliv, MPH

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Danielle Pavliv is an accomplished health policy analyst and consultant, with expertise in the areas of Medicare, Medicaid, and healthcare reform.

She collaborates with a range of clients across the healthcare spectrum to conduct policy analysis; project management, planning, and implementation; market analyses and strategy; and RFP development, writing, and review. She has also supported health plans with Medicare Advantage strategy, application submission, and Model of Care development.

With a background in health policy and experience as an analyst for a government relations firm in Washington, DC, she conducted analyses and assisted clients in successfully advocating for legislation and regulations related to Medicare fee-for-service payment policy and innovation, Medicare prescription drug coverage and pricing issues, Affordable Care Act (ACA) implementation and Medicaid expansion, and healthcare competition, among others.

Danielle helps clients create thoughtful, thorough business plans and leads project management efforts to successfully execute and implement large-scale organizational changes and new business implementation. She has worked closely with health plans serving Medicare, Medicaid, and commercial populations, and has proven experience as a partner to these organizations.

Danielle earned a Master of Public Health in health policy from the George Washington University and a bachelor's degree in sociology from the University of North Carolina at Chapel Hill.

Jennifer Podulka

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Jennifer Podulka is an experienced project manager with extensive research and data analysis expertise. Much of her work has focused on physician payment policy, traditional Medicare, and Medicare Advantage including work with special needs plans and encounter data, the Medicare Part D exceptions and appeals process, and the federal budget and broader healthcare system context for Medicare policy.

Blending skills in research project management and technology, Jennifer has drawn on her Medicare experience to address the unique needs of different types of clinicians in a variety of work environments. She excels in managing research staff, as well as concurrent projects, resulting in organized and tailored final reports, analysis, and other deliverables.

Before joining HMA, she was responsible for designing, conducting, and publishing studies in Medicare Payment Advisory Commission (MedPAC) reports to Congress on Medicare payment policy, as well as analyzing and presenting data on specific Medicare Advantage, traditional fee-for-service Medicare, and broader healthcare system issues as they intersect Medicare policy.

Well versed in presenting findings to leaders within MedPAC, the Centers for Medicare and Medicaid Services (CMS), and other organizations, Jennifer earned a bachelor's degree in political science and government and a Master of Public Affairs from the LBJ School at the University of Texas, Austin.

Mary Russell, MPH

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Mary Russell specializes in developing and evaluating managed care, quality improvement, and health education programs for Medicare and dually eligible populations.

Prior to joining HMA, Mary was a clinical project manager at L.A. Care Health Plan, where she implemented and evaluated quality improvement programs for duals and led initiatives to integrate product and clinical operations. She also managed cross-functional workgroups to launch the Duals Demonstration pilot and provided ongoing coordination between product and clinical operations.

Mary was also responsible for maintaining the Medicare model of care to ensure regulatory standards were met while monitoring and evaluating quality metrics.

She led implementation of a high-touch care management approach to increase member engagement and improve health outcomes for nearly 15,000 dual eligibles in L.A. County. This included developing an in-home assessment, managing a vendor to conduct the assessment, developing training materials, and working within the existing information technology infrastructure to integrate assessment results into member care plans. She also contributed to the development of L.A. Care's overall Medicare product strategy and interpreted and operationalized regulatory policy.

Prior to L.A. Care, Mary collaborated with public health and pharmaceutical organizations on health education and behavior change programs. She managed the research, development, implementation and evaluation of initiatives, including data analysis, stakeholder engagement, public-private partnerships, provider training, and national and international media outreach.

Mary earned her master's degree in public health from the University of California, Berkeley and her bachelor's degree in communication from Villanova University.

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