

JANUARY 2016

Manatt on Medicaid: 10 Trends to Watch in 2016



Introduction

Medicaid continues to gain scale and importance nationally – as both the leading source of health coverage for Americans, and as a change agent within the healthcare marketplace.

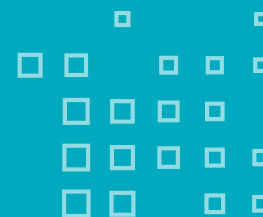
With the number of Americans obtaining health coverage through Medicaid at an all-time high, and mounting evidence of the benefits of Medicaid expansion – to patients, providers, and states – 2016 will be a year of continued growth and change.

Interest in Medicaid expansion will remain high, enabled by the Centers for Medicare & Medicaid Services' (CMS) willingness to consider alternative expansion designs. With the foundation of coverage laid and the push for payment and delivery system reform occurring in all parts of the healthcare system, expect states to ramp up their efforts to extract more value for their dollar. New payment vehicles that incentivize providers to adopt more effective and efficient models of care will continue to gain steam, along with renewed focus on the highest-cost and highest-need patients, including the frail elderly, the disabled, justice-involved populations, and those with serious mental health and substance abuse problems.

Finally, with a Presidential election on the horizon, there will be enormous pressure on federal regulators to secure the legacy of the past eight years. Expect a flurry of activity from CMS in these next months – finalizing regulations, upgrading systems, setting parameters on waivers, and generally tying up loose ends – efforts that will be hampered, but not halted, by accelerating staff turnover in anticipation of a new Administration, and continued scrutiny in the politically charged lead-up to election day.

Trends to Watch

Continued Growth and Change in 2016



Trend 1 Medicaid Expansion Continues to Gain Traction

Expect state interest in expansion to continue in the coming year, and existing expansion states to stay the course. With hard data linking expansion to state budget savings, gains in coverage, and reductions in hospital uncompensated care costs, the economics are just too compelling.

Trend 2 Data Takes Center Stage in Delivery System Transformation

Medicaid-driven healthcare transformation is no longer a trend – it’s a way of doing business. And data is the fuel that powers these efforts. Expect increasing investment in data analytics and the exchange of health information, as states seek to ratchet down per capita spending, payers feel increasing

pressure to incentivize provider accountability, and providers seek to move up the payment food chain.

Trend 3 Continued Evolution and Innovation for Medicaid Managed Care

Enabled by proposed regulations that confirm state authority to advance value-based payment arrangements, and provide flexibility to cover new services, provider types and sites of care under managed care arrangements, expect states to take a more active role in shaping the payment terms between managed care companies and healthcare providers.

Trend 4 New Opportunities for Improving and Integrating Behavioral Health

As the march toward better, more integrated care continues, look for more states to bring

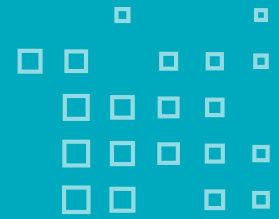
behavioral health services into their managed care benefits, increased pressure to amend federal rules governing the sharing of information about substance use disorders, and new thinking from the Administration on how to modernize Medicaid’s role as a payer for substance abuse treatment.

Trend 5 Moving Beyond Medical Services to Tackle the Social Determinants of Health

With mounting evidence-based research and an increasing recognition among states that social issues directly affect health outcomes and the cost of care, expect increased pressure to define the parameters of permissible payment under Medicaid and increased creativity among providers and payers, as they seek to blend resources and develop new strategies to address these needs.

Trends to Watch

Continued Growth and Change in 2016



Trend 6

Rebalancing, Integration and Workforce Supports – Momentum Builds for LTSS Reform

With Medicaid continuing to be the largest payer for long-term services and supports (LTSS) and demand increasing, look for continued efforts to “rebalance” LTSS with a shift to home and community-based services, tighter integration of LTSS with the rest of the care continuum, and an increased focus on workforce supports.

Trend 7

Linking Medicaid and Criminal Justice Systems – Better Health, Reduced Costs, Less Recidivism

With a spotlight on mass incarceration, states’ increasing desire to invest in community-based supports for justice involved populations, and the Medicaid expansion enabling coverage for most ex-inmates, expect to see a new level of

coordination across criminal justice and state Medicaid agencies, as states seek to leverage the broad range of Medicaid covered services to save costs and improve outcomes in the criminal justice system.

Trend 8

More Change Coming for Supplemental Payments

Fueled by the shift toward more value-based purchasing, as well as increased federal scrutiny, state reliance on Medicaid supplemental payments is likely to undergo considerable change in 2016 and beyond. Given hospital and state reliance on these payments, the path forward will be not easy.

Trend 9

Access and Affordability Tensions Continue for Prescription Drugs

Expect the push and pull of pharmaceutical pricing and patient access to continue

throughout 2016, spiking each time a new life-saving drug is introduced. While the issue is not unique to Medicaid, it is a particularly sensitive one given the demographics of the Medicaid population, state budgetary pressures, and the requirements of federal Medicaid law.

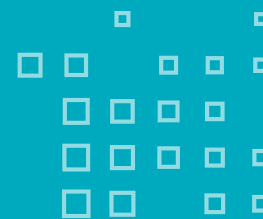
Trend 10

State Innovation Waivers Provide a New Angle in the Coverage Expansion Debate

While State Innovation Waivers apply to Marketplaces, not Medicaid, for states that haven’t expanded Medicaid to date, the flexibility to tailor a combined approach to Medicaid and subsidized private market coverage may generate new interest in Medicaid expansion. Expect more states to look than to act – fashioning a new coverage continuum is a heavy lift, and recent federal guidance indicates less flexibility than some had hoped.

Trend 1

Medicaid Expansion Continues to Gain Traction



By the end of 2015, 30 states plus the District of Columbia had expanded their Medicaid programs to adults with incomes below 138 percent of the Federal Poverty Level (FPL). Four states implemented expansion in 2015: Montana, Alaska, Indiana and Pennsylvania. At the same time, governors in Utah, Tennessee and Virginia advanced expansion, only to be rebuffed by their respective legislatures. Despite the upcoming Presidential election and the impending reduction in the federal matching rate (from 100 percent to 95 percent in 2017), we expect state interest in expansion to continue in the coming year; and we do not expect any expansion state to reverse course. As we predicted (correctly) last year, the economics are just too compelling.

Fueling the momentum is hard data. By the second quarter of 2015, economic data from early expansion states began to emerge showing that expansion generated significant savings and new revenues.

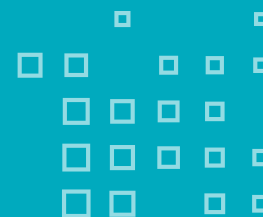
Both Arkansas and Kentucky brought in outside consultants who confirmed the savings and revenue figures and concluded that the elimination of expansion would cause budget shortfalls in the hundreds of millions of dollars. National studies found that expansion states had lower Medicaid costs and made the greatest gains in coverage, and concomitantly saw the greatest reductions in hospital uncompensated care costs, with implications for the stability of rural hospitals.

The fact that 2016 is the final year of full federal funding may spur more states to expand, and will certainly trigger additional scrutiny of the budget implications. More economic data will emerge in 2016, coupled with early findings on healthcare access and outcomes. And, with policy leaders of both political parties committed to reducing rates of incarceration and tackling the opioid epidemic, expect increasing recognition of Medicaid expansion's central role in achieving these goals.

Since approval of Arkansas's expansion waiver in 2013, CMS has made clear its willingness to work with states in crafting expansions that reflect a state's healthcare landscape and values, so long as these "alternative" expansions advance the goals of the Medicaid program. Alternative expansions will continue to be front and center – both for states seeking to expand and for states seeking to reconfigure existing expansion approaches.

Trend 2

Data Takes Center Stage in Delivery System Transformation



Medicaid-driven healthcare transformation and payment reform is no longer a trend – it is a way of doing business for state Medicaid programs. With growth in the number of covered lives, sustained pressure to reduce program costs, and the availability of federal funding for initiatives ranging from health homes to multipayer State Innovation Models, virtually every state in the nation has begun to shift away from purchasing volume and towards new value-based models of delivering and paying for care. These efforts vary broadly, from bundled payments (TN), to value-based purchasing requirements in managed care contracts (MA, NY, OH, PA), regional provider-driven care management organizations (AL, CO, OR), and in a growing number of states, Delivery System Reform Incentive Pools (CA, KS, MA, NJ, NY, TX, and more recently, proposals in AL, NH, and WA).

Data – more specifically, the capacity to share and analyze data – is the fuel that powers these reform efforts. Yet, states

and providers have struggled to get access to the comprehensive and integrated claims and clinical data necessary to undergird the shift to value-driven systems of care. In addition to the data itself, people with the skills and training in the methods needed to analyze this data – including predictive modeling, risk scoring, and patient stratification – are hard to come by.

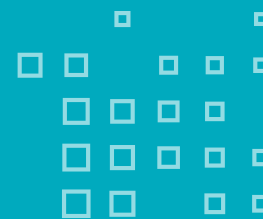
In the year ahead, expect increasing investment among Medicaid stakeholders at every level in data analytics and the exchange of health information, as states seek to ratchet down per capita spending, payers feel increasing pressure to incentivize provider accountability, and providers seek to move further up the payment food chain. Building upon significant but still not fully realized investments over the past decade in electronic health record (EHR) adoption, health information exchange, and all payer claims databases, and leveraging multiple existing, if imperfect, data sources, states will be focused on both setting statewide metrics for standards-

driven care and investing in the infrastructure needed to support data analytics and health information exchange.

One state to watch: New York. As part of its \$6.4 billion Delivery System Reform Incentive Payment (DSRIP) investment, New York has committed to building a user-friendly Medicaid Analytics Performance Portal, which the state envisions will house performance dashboards, act as a data warehouse, and serve as an electronic care planning tool for regional integrated delivery networks charged with meeting state-defined performance metrics, including transitioning to value-based payments, over the next five years. No matter what the outcome, there are likely to be lessons learned from this ambitious effort.

Trend 3

Continued Evolution and Innovation for Medicaid Managed Care



Managed care is the dominant delivery model in Medicaid, with the majority of Medicaid beneficiaries accessing some, if not all, of their healthcare through managed care arrangements across 39 states. With more than a decade of experience managing the care of relatively healthy Medicaid beneficiaries, states are extending their managed care programs to serve more complex populations – including dual eligibles, beneficiaries with serious mental illness and substance abuse disorders, and those with developmental disabilities. Recognizing the value of integrated models of care, states also are covering a broader range of Medicaid services under capitated arrangements, reversing long-standing carve-outs for benefits such as behavioral health, pharmacy, and long-term care services.

At the same time, states are taking a more active role in shaping the payment terms between managed care companies and healthcare providers. No longer content

to capitate their Medicaid payments and stand aside as plans pay providers on a fee-for-service basis, states are increasingly leveraging managed care contracts to ensure that plans are using value-based payment arrangements with their network providers, holding providers accountable and sharing savings (and sometimes losses) with those providers. A growing number of states now contractually require Medicaid managed care plans to transition a significant and growing portion of provider payments from fee-for-service to value-based purchasing. Such arrangements are seen as critical to the sustainability of delivery reforms aimed at improving quality and efficiency of care.

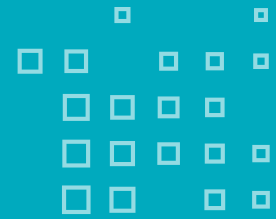
While state Medicaid managed care programs have grown and changed dramatically over the last decade, federal regulation of managed care had not changed significantly since 2002. But in May of 2015, federal officials proposed sweeping regulatory reform, spanning a wide range of topics including beneficiary choice,

network adequacy, appeals, Medical Loss Ratios, and actuarial soundness. Notably, the regulations explicitly permit state contracting strategies that advance value-based payment arrangements between plans and providers, and provide more flexibility for plans and providers to rely on services, provider types and sites of care that would not otherwise be covered by Medicaid.

Keep an eye out for finalized regulations in 2016. With nearly 900 comments from states, plans, providers, and advocates – reflecting considerable pushback in areas where stakeholders see CMS as “overreaching” – it is likely that not all proposed policies will remain intact.

Trend 4

New Opportunities for Improving and Integrating Behavioral Health



One in five Medicaid beneficiaries has a behavioral health diagnosis; yet these beneficiaries account for almost half of total Medicaid expenditures. In 2016, policymakers, plans and providers will continue to wrestle with how to more effectively deliver integrated, high-quality behavioral healthcare to this high-need population – a challenge made all the more pressing by the growth in newly eligible adults. Expect more states to include a broad array of behavioral health services in their managed care benefits, creating a stronger foundation from which to pursue their clinical integration efforts and to explore alternative payment models that incentivize coordinated care.

With the opioid epidemic wreaking havoc in communities across America, state and federal policymakers will be looking to Medicaid as a key part of any solution. In July of 2015, CMS issued a State Medicaid Director letter that describes new opportunities for states to use 1115 waivers to revamp their substance use disorder delivery systems in Medicaid, including

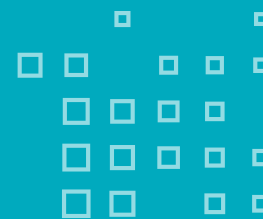
potentially the ability to get federal Medicaid matching funds for some expenses of Institutions for Mental Disease (IMDs). In combination with the proposal in the Medicaid managed care rules to allow for managed care plans to finance short-term IMD stays under limited conditions, it is a powerful signal that the Administration is eager to rethink and modernize Medicaid's role in providing substance abuse treatment.

In 2016, also look for pressure to amend 42 CFR Part 2, the federal rules governing the sharing of information about substance use disorders, cited by many as a major barrier to integrated care. The Administration has signaled that it might have some (sharply) limited flexibility to modify the regulatory language. If mental health legislation is adopted in Congress, we may see even more sweeping changes. Even without legislative or regulatory changes, though, we expect plans, providers and consumer advocacy organizations to spend more time looking for practical solutions to the longtime conundrum – how do

we ensure that providers have the information that they need to provide truly integrated care for Medicaid beneficiaries (and others) while still protecting patient privacy and confidentiality around sensitive behavioral health conditions and treatments? These might include greater use of information technology to categorize and segment data into what can be readily shared and what cannot, or more streamlined written authorization procedures for the sharing of information.

Trend 5

Moving Beyond Medical Services to Tackle the Social Determinants of Health



With mounting evidence-based research and an increasing recognition among states that social issues – such as unstable housing, unemployment, chaotic family lives, violence, and environmental pollution – directly affect the health outcomes and cost of care of Medicaid beneficiaries, expect increased interest in the year ahead in exploring the parameters of permissible payment under Medicaid and increased creativity among providers and payers, as they seek to blend resources and develop new strategies to address these needs.

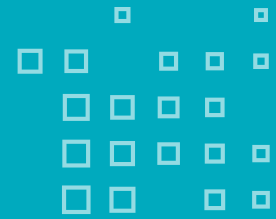
With states increasingly downloading risk to health plans and providers, these entities are searching for smart ways to address social determinants of health, thereby improving the health and reducing the costs of the patients and populations for which they are responsible. While the connection between

social issues and health is well-established, and state interest in responding is strong, one question for the year ahead will be how far can Medicaid go in paying for social services? CMS issued a State Medicaid Director letter earlier this year that offers clear guidance in the housing arena – Medicaid can't pay for room and board, but it can provide services that assist people in finding and keeping stable housing. Even so, questions remain. For example, can managed care plans use capitation funds to play a more active role in helping a beneficiary with housing and, if they do, how is this later reflected in their Medicaid managed care rates? What about other social services, such as assistance filling out Supplemental Nutrition Assistance Program (SNAP) applications or finding a job? It is neither fiscally nor politically feasible for Medicaid to step

in and fill all of the social services gaps, but we anticipate that states, plans, providers, advocates and others will be pushing the envelope in the year ahead as it becomes ever more apparent that social determinants of health are a critical part of improving health outcomes while containing healthcare costs.

Trend 6

Rebalancing, Integration and Workforce Supports – Momentum Builds for LTSS Reform



Medicaid continues to be the largest payer for long-term services and supports (LTSS) – accounting for more than half of the \$300-plus billion spent nationwide annually. And with demand for LTSS increasing, in part due to a rapidly aging population, calls for reform have grown louder. In the year ahead, expect these calls to be met by continued efforts to “rebalance” LTSS with a shift to home- and community-based services (HCBS), tighter integration of LTSS with the rest of the care continuum, and an increased focus on workforce supports.

The percent of LTSS expenditures spent on HCBS has steadily risen over the past twenty years, up from under 20% in 1995 to nearly 50% by 2013, yet still varies greatly from state to state. As of early 2015, all but five states had taken advantage of HCBS options created or enhanced by the Affordable Care Act (ACA). Expect states to

continue to move populations into community-based settings, even as some of the federally funded programs providing enhanced funding, such as the Balancing Incentive Program, begin to sunset.

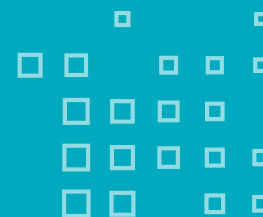
Awareness about the need to more tightly integrate LTSS into the care continuum is increasing, but stakeholders remain in the very early stages of implementation. At the federal level, CMS’s proposed regulations for Medicaid managed care included a focus on LTSS for the first time; and states continue to move towards managed LTSS (MLTSS). In 2015, 33 states reported operating or considering implementing an MLTSS program, up from 27 states in 2014. However, broader efforts at integration are still nascent. For example, nine states have implemented Medicaid Accountable Care Organizations and nine more are considering doing so; yet most

do not include LTSS. In the year ahead, look for states to continue to explore ways to better integrate LTSS into innovative financing and care delivery models.

Finally, as the demands for LTSS increase, so do the demands on direct care workers and informal caregivers. The Senate recently passed the Recognize, Assist, Include, Support and Engage (RAISE) Family Caregivers Act, and 18 states have enacted the CARE Act, both of which create additional supports for informal caregivers. Keep an eye out for additional supports for the LTSS workforce in 2016.

Trend 7

Linking Medicaid and Criminal Justice Systems – Better Health, Reduced Costs, Less Recidivism



With a spotlight on mass incarceration, states' increasing desire to invest in community-based supports for justice-involved populations, and the Medicaid expansion enabling coverage for most ex-inmates, expect to see a new level of coordination across criminal justice and state Medicaid agencies in the coming year. The broad range of services covered under Medicaid – including treatment for mental illness, substance use disorders, and chronic illness – provides an opportunity for states to treat the disproportionately high numbers of Medicaid-eligible individuals who are involved in the justice system.

In the year ahead, increased coordination across the two systems will initially focus on identifying potential savings in states' criminal justice and social services budgets. In states that expanded Medicaid, the most immediate source of criminal justice savings has come from the state's claiming of federal matching funds for the cost of care for 24 hours or more in a community medical

institution. States with Medicaid expansions, such as Colorado, Michigan and Ohio, have already seen a savings of \$5 million to \$10 million a year. Other states, such as Mississippi, North Carolina and Louisiana, have also reported savings from using Medicaid to pay for inpatient care, despite their decision not to expand. Look for a push from advocates pressing CMS to consider an 1115 Waiver of the "inmate exclusion" to allow states to use Medicaid to finance some healthcare for those who are incarcerated, with a particular focus on services required to assure a smooth transition back into the community.

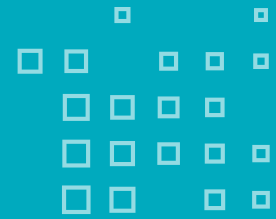
States and local jurisdictions are also looking to strengthen the linkages between the criminal justice and Medicaid systems as a way of preventing new incarceration and recidivism. This year more states may begin to implement enrollment and care coordination strategies at the front and back end of an individual's involvement in the justice system. For example, some states and

local jurisdictions are setting up mechanisms that enroll individuals upon detainment as part of their intake process. Upon reentry into the community, newly Medicaid-enrolled individuals are able to access needed behavioral and physical health treatment and medication. States and localities also are exploring innovative strategies to develop Medicaid care coordination and treatment plans upon discharge from the justice system, including setting up medical appointments and making referrals to needed social services and resources.

Early results from state efforts to link Medicaid and criminal justice systems are promising – offering the potential to both save costs and reduce the social burdens of crime in communities – making this an issue to watch in 2016.

Trend 8

More Change Coming for Supplemental Payments



Fueled by the shift toward more value-based purchasing, as well as increased federal scrutiny, state reliance on Medicaid supplemental payments is likely to undergo considerable change in 2016 and beyond. As the term suggests, these payments supplement regular base payments to Medicaid providers—most often hospitals. The type of payments attracting attention are referred to as “upper limit” payments because they cannot exceed an upper payment limit (UPL) set by reference to what Medicare would pay, in the aggregate, for the same services to the same types of providers.

Supplemental payments are intended to compensate hospitals for the cost of caring for uninsured patients as well as for Medicaid underpayment. Reliance has grown in part because recession-triggered budget constraints prompted states to reduce or freeze hospital rates. To fill the gap, hospitals – or the local jurisdiction that supports them – generate supplemental

payments by putting up the nonfederal share through intergovernmental transfers or provider taxes. Supplemental payments are particularly important for safety net hospitals that have limited ability to compensate for low Medicaid rates or the cost of serving the uninsured.

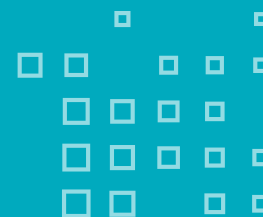
The problem is that supplemental payments flow outside the regular reimbursement system delinked from services and patients under often-contorted allocation formulas. Lack of transparency and accountability have led to multiple General Accountability Office reports and congressional hearings. Supplemental payments can also detract from state initiatives to advance risk-based arrangements and value-based purchasing. It is challenging to move to value-based payment if much of the payments to providers stand apart from the regular reimbursement system; in some states, supplemental payments account for 30 percent or more of Medicaid hospital payments.

These issues could be resolved by folding the supplemental payments into base reimbursement rates. But that is not so easy. It is not clear to what extent hospitals and counties will be willing to put up the nonfederal share if the dollars are no longer allocated back – more or less – to the same hospitals.

Change is likely. CMS has signaled in the waiver context and in proposed managed care regulations that Medicaid payments should be tied to services provided to Medicaid enrollees, base payments should be at levels sufficient to ensure access to care, and payments to health plans and providers should promote value and contribute to better management and coordination of care. In light of hospital and state reliance on these payments, the path forward will not be easy.

Trend 9

Access and Affordability Tensions Continue for Prescription Drugs



A year ago, we called out the increasing tension between price and access. While federal law requires state Medicaid programs to include on their formularies drugs for which the manufacturer offers the statutory rebate, states are limiting access to some high-priced specialty drugs that cannot be accommodated in their budgets. The tension – which, of course, is playing out in the private sector as well – will continue into 2016. However, at the end of 2015, CMS reaffirmed the rules governing Medicaid drug coverage. States in both their Medicaid fee-for-service and managed care programs must cover any outpatient drug for which the manufacturer provides the required 27% rebate. Utilization control through prior authorization is permitted, but states may not use that process to impose conditions for coverage that unreasonably restrict access to drugs.

The situation that prompted CMS to issue a Medicaid Program Drug Rebate Notice in November 2015 centered

around the new drugs available to treat and cure Hepatitis C. While states may subject a covered outpatient drug to prior authorization, studies showed that states were imposing conditions that restricted access to clinically appropriate and medically necessary treatments and instructed states to look to the drug’s labeling or to appropriate clinical compendia in crafting their coverage policies. In its bulletin to states, CMS also instructed states to monitor drug coverage policies of their managed care organizations to assure that Medicaid managed care enrollees likewise have appropriate access to medically necessary medications. A similar requirement was included in the proposed Medicaid managed care regulations published in May 2015.

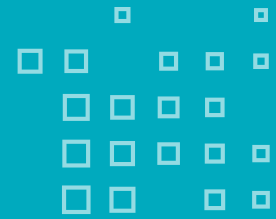
Cognizant of state budget pressures and rising drug costs, simultaneously with issuance of the Drug Rebate Notice, HHS reached out to several pharmaceutical companies and asked them to provide information on pricing arrangements and ideas to

support the provision of these “lifesaving” medications to Medicaid programs at sustainable prices.

Expect the push and pull of pharmaceutical pricing and patient access to continue throughout 2016, spiking each time a new lifesaving drug is introduced. While the issue is not unique to Medicaid, it is a particularly sensitive one given the demographics of the Medicaid population, state budgetary pressures and the requirements of federal Medicaid law.

Trend 10

State Innovation Waivers Provide a New Angle in the Coverage Expansion Debate



What does Section 1332 of the ACA – State Innovation Waivers – have to do with Medicaid? On its face, nothing.

State Innovation Waivers give states flexibility to modify the private market coverage terms of the ACA to state needs, goals and market conditions. States can, for example, propose alternative approaches to providing marketplace coverage, allowing states to receive the aggregate value of the federal funding that would have gone directly to individuals or small businesses for tax subsidies, or modify or eliminate the employer or individual mandate. But there are parameters around State Innovation: waivers must provide coverage that is at least as comprehensive and as affordable to at least the same number of people without contributing to the federal deficit. In the final days of 2015, the Department of Health and Human Services (HHS) and Treasury issued guidance evidencing the rigor with which they will review these guardrails.

While there has been considerable discussion and a

fair amount of misinformation about 1332 waivers as a vehicle for reforming Medicaid, the authority to initiate Medicaid reform has always been and remains 1115 waivers. So, where do 1332 and Medicaid waivers intersect? For states thinking broadly about their coverage continuum as the foundation for healthcare delivery system and payment reform, “1332 fever” is sparking new ideas about how to reform, better leverage and even expand Medicaid.

The ACA encourages states to coordinate 1332 and Medicaid 1115 waivers (and Medicare waivers, for that matter) to align coverage programs toward achieving state healthcare reform goals. At its most straightforward, state coordination of 1332 and 1115 waivers could be used to smooth the differences among Qualified Health Plan (QHP) coverage, Medicaid and the Children’s Health Insurance Program (CHIP) – including differences in eligibility rules, covered benefits, networks, and cost sharing. States thinking more “out of the box” are contemplating how

to use combined 1332 and 1115 waivers to align quality and payment initiatives across the coverage continuum. The most innovative states may consider combining 1332 and 1115 waivers to create state-specific affordability scales that smooth health insurance subsidies for people with incomes from 0 to 400 percent of the FPL. For states that haven’t expanded Medicaid to date, the flexibility to tailor a combined approach to Medicaid and subsidized private market coverage may generate new interest in Medicaid expansion.

Expect more states to look than to act – fashioning a new coverage continuum is a heavy lift, and recent federal guidance indicates less flexibility than some had hoped. Nevertheless, given that State Innovation Waivers may be implemented beginning on January 1, 2017, we expect 1332 and related 1115 waiver development to accelerate in 2016.

About Manatt

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid expansion, redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 80 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states. For more information about Manatt Health, contact www.manatt.com/HealthcareIndustry.aspx.

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