HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WE REVIEW THE WASHINGTON STATE MEDICAID BLOCK GRANT LEGISLATION

HMA ROUNDUP: CA LEGISLATURE HAS UNTIL JUNE 15 TO PASS BUDGET OR GIVE UP PAYCHECKS; FL BEGINS REGIONAL STAKEHOLDER MEETINGS ON MANAGED CARE EXPANSION FRIDAY; GA MANAGED CARE DESIGN WINNER SECRET UNTIL LATE JULY; IL WILL DELAY PROVIDER PAYMENTS TO AVOID RATE CUT; IL HEALTH INFORMATION EXCHANGE RFP LIKELY TO ATTRACT LARGE IT BIDDERS

OTHER HEADLINES: CO EXCHANGE BILL SIGNED LAST WEEK; AL AND DE GOVERNORS REJECT MEDICAID CUTS; LA MEDICAID CCN PLAN QUESTIONED BY GOOD-GOVERNMENT GROUP; MA APPROVAL OF HEALTH REFORMS RISES, NOT FOR INDIVIDUAL MANDATE; TX SENATE PASSES HEALTH REFORM BILL, INCLUDES MANAGED CARE EXPANSION

PRIVATE CO. NEWS: WELLPOINT ACQUIRES CAREMORE FROM CCMP FOR $800 MILLION; VANGUARD SETS IPO TERMS, MARKET CAP OF $1.64 BILLION; CIT GROUP INC. SUPPORTS $204 MILLION REFINANCING OF ERNEST HEALTH

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JUNE 8, 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: WASHINGTON MEDICAID BLOCK GRANT BILL

This week, our *In Focus* section explores legislation in Washington state to apply for a Medicaid block grant waiver from the federal government. The bill (SB 5596), introduced earlier this year, was passed by the state legislature and signed into law by Governor Gregoire last week. We reviewed the Rhode Island block grant waiver several weeks ago, noting that while it potentially provided a look at what block grants could look like under the Ryan Budget proposal, increased federal allotments and questionable new authorities granted to the state did not make it an ideal example of the future of block grants. Where the Rhode Island waiver appeared to bundle several areas of flexibility in administering their Medicaid program and provided no real federal or state savings, the Washington bill aims to reduce the growth in health care costs, preserve the safety net, and better manage care.

The Governor's approval of the bill came as a bit of a surprise, as she had previously been one of several governors to publicly oppose the Ryan proposal. Governor Gregoire is expected to meet with Health and Human Services (HHS) Secretary Kathleen Sebelius this week to discuss the bill and waiver application. The state is to submit their request to the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) no later than October 1, 2011. If necessary, the state will apply for waiver authority under a Section 1115 demonstration waiver.

While the details of the waiver proposal will not be set until later this year, SB 5596 provides the framework that will guide the waiver design process. The key feature of the legislation is that the state is seeking to replace the traditional matching formula with a negotiated capitation payment that varies based on a beneficiary's eligibility group. We believe at this time that the state would be getting a capitated, per member payment from the federal government, to which it would add its contribution, and then pass the combined amount to the Medicaid managed care plans.

In terms of the outlook for this waiver request, we note that while the federal government has indicated its distaste for Representative Ryan's block grant proposal, this waiver comes from a progressive state with a Democratic governor. As such, we expect the bill will generate significant consideration by the administration. Interestingly, a number of the elements in the proposal, which we describe in detail below, are similar to items included in New Jersey's waiver proposal which we described in our May 25th *Weekly Roundup*. These include updating the state's eligibility system, supporting the development of payment reforms including Accountable Care Organizations (ACOs), and encouraging beneficiaries to enroll in private insurance either through exchanges or their employers where available.

Key Features

- The new state flexibility in managing its Medicaid program will be built on the success of the state's existing basic health plan and transitional bridge waiver. The existing waiver incorporates consumer participation and choice, benefit design flexibility, and payment flexibility have helped keep Medicaid costs low.

- The demonstration program will be designed to maximize federal financial participation under a combined Medicaid and CHIP program.
- The program will be funded through eligibility group-based per capita payments indexed to a base year. Federal payments for each eligibility group will be based on the product of the negotiated per capita payments multiplied by the actual caseload for the group. Per capita payments will:
    i. Be based on targeted per capita costs for the full duration of the demonstration period;
    ii. Include consideration and flexibility for unforeseen events, changes in health care delivery, and changes in federal or state law;
    iii. Take into account the effect of the Affordable Care Act (ACA) on federal resources devoted to Medicaid and CHIP.
- The program will cover benefits deemed to be essential health benefits under Sec. 1302(b) of the ACA. Additional covered benefits will be provided to select eligibility groups, such as children, pregnant women, and disabled and elderly individuals.
- The program may institute "limited, reasonable, and enforceable" cost sharing and premiums intended to encourage appropriate utilization. Access to preventative and primary care services will not be impacted.
- As part of the demonstration, Washington will streamline the eligibility determination process.
- Payment reform initiatives such as bundled payments, global payments, and risk-bearing payment arrangements will be considered. These payment reforms will be guided by the aims of effective purchasing and efficient use of health services. Additionally, payment reforms that encourage health homes and ACOs will be included.
- The program will encourage enrollment in coverage through the insurance exchange and employer sponsored insurance where available. SB 5596 grants authority to require enrollees to remain in their chosen plan for the calendar year.
- Additional payment reform initiatives, including capitated or global payment of special add-on payments, will be developed for federally qualified health centers and rural health clinics.
- The proposal seeks an expedited 45-day process for CMS to review the state's proposal and respond to state requests for changes to the demonstration project once implemented.
- There will be multiple opportunities provided for stakeholders and the general public to review and comment prior to the October 1 application deadline.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

This week is crucial in the budget process, as the legislature considers the governor's revised budget from last month. The state Controller has said that if the legislature has not passed the budget by June 15, lawmakers will receive no pay, on a per diem basis, for the days they work. A big issue is the transition of Healthy Families enrollees to Medi-Cal, while keeping the taxes that fund 180,000 Healthy Families child enrollees. Rates under Medi-Cal would be 25-30% less for the exact same coverage.

The roll out of mandatory managed care enrollment for seniors and persons with disabilities (SPD) has begun everywhere but Kern County.

In the news

- **Calif. Medicaid cuts pit HHS vs. DOJ**

  Much of the health policy world was stunned when acting Solicitor General Neal Katyal filed an amicus brief in a Supreme Court case on May 26 arguing against Medicaid patients and providers suing California over changes to its Medicaid program. Advocates for Medicaid beneficiaries say the case, *Douglas v. Independent Living Center of Southern California*, is important because it will be very difficult to enforce states' obligations under Medicaid if the Supreme Court accepts Katyal's argument. This could not only hurt beneficiaries who would have little recourse if Medicaid denies lifesaving benefits, but it could also undermine the Patient Protection and Affordable Care Act, which relies on states to implement key components. The court will hear the case in the next term. (Politico)

- **The Other Health Care Lawsuit: California Medicaid Case Headed To Supreme Court**

  In the legal battle over reimbursement cuts, the U.S. 9th Circuit Court of Appeals ruled against the state in several cases. In January, the Supreme Court agreed to hear the case, based on Santa Rosa Memorial's suit and two others. The court will focus on whether outside groups, such as hospitals and other providers, as well as Medicaid recipients, have the right to sue when they believe the state is violating federal law. For now the state – barred by the 9th Circuit injunction – is holding off on the disputed cuts at issue in the lawsuit. (Kaiser Health News)

- **Assembly OKs health insurance regulation as GOP walks out**

  The Assembly passed one of the year's most controversial and intensively lobbied bills last Thursday -- imposing rate regulation on health insurers -- after Republicans walked out of the chamber in protest. GOP members wanted to call a caucus to discuss the measure, Assembly Bill 52 by Assemblyman Mike Feuer, D-Los Angeles, but Speaker John A. Perez refused to call a recess. Democrats then defeated a recess motion with leaders saying Republicans were trying to stall long enough to kill the bill because of last Friday's deadline for action. (Sacramento Bee)

Florida

HMA Roundup – Gary Crayton

Beginning this Friday in Tallahassee, the state is holding meetings in each of the 11 regions under the managed care expansion. The purpose of the meetings is to provide an opportunity for stakeholder comment on the Medicaid waiver application, which is due to be submitted by August 1. CMS is working with the state on a 90 day extension of the current waiver.

In the news

- **Florida governor signs historic Medicaid bill**

  Florida Gov. Rick Scott signed two historic Medicaid bills Thursday, placing the health care of nearly 3 million Florida residents into the hands of for-profit companies and hospital networks. Lawmakers said the program was overwhelming the state budget and needed to be privatized to rein in costs and improve patient care. Critics fear the bills build on a flawed five-county experiment where patients struggled to access specialists and doctors complained the treatments they prescribed were frequently denied. State Sen. Joe Negron, who spearheaded the overhaul, said leaders have learned from the pilot program's shortcomings and it now includes increased oversight and more stringent penalties, including fining providers up to $500,000 if they drop out. The measures also increase doctors' reimbursement rates and limits malpractice lawsuits for Medicaid patients in hopes of increasing doctor participation in the program. The bills (HB 7107 and HB 7109) also require providers to generate a 5 percent savings the first year, which could save the state about $1 billion. (Palm Beach Post)

- **Hospitals told to raise $45 million or face additional reductions to their rates**

  Hospitals -- already facing a 12 percent reduction in their Medicaid rates in the next fiscal year -- could see deeper rate cuts in the coming months. The state Agency for Health Care Administration on May 24 sent a letter to hospitals advising them that there is a $45 million shortfall in intergovernmental transfers -- so called IGTs used to help fund hospital Medicaid rates. (The Current)

Georgia

HMA Roundup – Mark Trail

The Governor's newly-established health benefits exchange workgroup is made up of a broad range of competing factions, including liberal democrats, tea partiers, insurance brokers, and the insurance commissioner's office. As a result, there is the potential that little will be accomplished, at least in the near term. However, this is a showing by the Governor that he has made a good faith effort to include the full range of stakeholders and interest groups in the exchange design and development process.

Medicaid managed care design consultant bids were due to the state on June 1. The list of bidders is kept secret by the department, but a contract award winner is due to be announced in late July. The Medicaid managed care RFP is currently slated for release in July 2012.

The state has issued an RFP for non-emergency medical transportation worth roughly $60 million statewide. One vendor will be awarded in each of 5 regions. The Atlanta region is worth $25 million to $30 million on its own. Currently, one public company, Providence Service Corporation, holds a small contract in the East region worth less than $10 million.

In the news

- **Deal appoints group to study insurance exchange**

  Gov. Nathan Deal issued an executive order Thursday appointing a group of lawmakers, health care experts, state officials and advocates to study whether Georgia should create a health insurance exchange. The 26-member Georgia Health Insurance Exchange Advisory Committee must issue its recommendation by December 15. Deal's action comes after the state Legislature failed to approve a bill that would have established a similar group. Deal is opposed to the federal health care law, believes it makes sense for Georgia to study the issue while waiting for the courts to decide whether the health care law is unconstitutional. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Rather than implement a proposed 6% Medicaid rate cut, the state will extend the payment cycle to providers to meet budget constraints. Payments to physicians will be made within 30 days, while payments to hospitals will average 60 to 90 days.

The process of hospital payment reform has continued to progress over past several weeks, as the state seeks to transition away from a payment system based heavily on special add-on payments not related to utilization rates. As we previously reported, the department is strongly considering a transition to an diagnosis based payment system, and we expect that draft hospital rates will be released later this summer or early fall. Authorization and final rate-setting would likely occur in the spring of 2012. As part of the payment reform process, the state is likely to address readmission reforms as well.

The state issued an RFP for Health Information Exchange IT services, with bids due on July 22, 2011. We expect bidders to include large firms with IT focuses, such as Accenture, Deloitte, ACS and HP, as well as some smaller players.

In the news

- **3 hospitals seek suspension of new approvals**

  Three Chicago-area hospitals say a state board should wait to approve any new hospitals until Illinois establishes a Center for Comprehensive Health Planning called for in legislation. A lawyer sent a letter Tuesday on behalf of Sherman Hospital, Advocate Good Shepherd Hospital and St. Alexius Medical Center to the chairman of the state health facilities planning board. The hospitals say in the letter that a 2009 overhaul of Illinois health planning calls for a comprehensive state plan that would provide expert, independent analysis to the board. The health facilities planning board is set to consider applications for new hospitals from three health systems during its June 28 meeting. (Crain's Chicago)

OTHER HEADLINES

Alabama

- **Alabama pushes health reforms**

  Last week, Republican Gov. Robert Bentley issued an executive order to move forward on an Alabama health insurance exchange and lashed out at the state's Republican-controlled Legislature for attempting to scale back his proposed $247 million increase in Medicaid funding by a mere $7 million. (Politico)

Colorado

- **Colorado latest state setting up health exchange**

  Colorado Governor John Hickenlooper signed a bill into law last Wednesday setting up a health insurance exchange. Democratic and Republican sponsors planned to join the governor for the signing and herald the step as a cost-saver for small businesses and individuals seeking health insurance. But some conservatives complain the exchange means Colorado is acquiescing to the federal health law, and they're already working on primary challenges to Republicans who supported the measure. Opponents point out that Colorado is among the states suing the federal government over the law. (Daily Camera)

Connecticut

- **Senate passes SustiNet compromise bill**

  A compromise bill on the proposed SustiNet state-run insurance plan passed the Senate 22 to 14 Monday, clearing the way for Gov. Dannel P. Malloy's signature. The bill does not commit the state to offering insurance to the public, although it does not rule it out. Instead, it establishes an advisory board called the SustiNet Health Care Cabinet to address health policy issues, including an examination of alternatives to private insurance, and an Office of Health Reform and Innovation to coordinate state and federal health reform efforts. (CT Mirror)

Delaware

- **Medicaid cost cuts rejected**

  The Joint Finance Committee voted 8-4 to restore $5 million to the $589 million program, rejecting proposals to limit Medicaid recipients to three trips to the emergency room each year, implement co-pays for visits to doctors or therapists, and temporarily cut payments to physicians and radiological services. (Delaware Online)

Idaho

- **Idaho fines prison health care company $382K**

  The company responsible for providing medical care to Idaho prison inmates has been fined nearly $400,000 by state officials for failing to meet some of the most basic health care requirements outlined by the state. The fines against Correctional Medical Services, totaling more than $382,500, were uncovered through a series of public records requests by The Associated Press. (Idaho Statesman)

Louisiana

- **Gov. Bobby Jindal's Medicaid plan questioned by good-government group**

  Calling it a "dubious privatization venture," a Baton Rouge good-government group last week questioned Gov. Bobby Jindal's plan to turn over large chunks of the state Medicaid program to private insurers and praised the Louisiana House of Representatives for trying to slow the process. Citing problems with similar privatization plans in other states, the nonpartisan Public Affairs Research Council raised doubts about whether the Coordinated Care Networks, which are slated to launch in January, would yield the cost savings and quality improvements the administration is promising. (NOLA.com)

- **DHH keeps contract winner secret**

  Louisiana is keeping secret the winning vendor that will handle claims processing and information systems for the state's $6.6 billion Medicaid health insurance program for the poor. The current annual operating cost for the Medicaid Management Information System contract is $34 million, according to DHH's website. (2theAdvocate.com)

Massachusetts

- **Support for state health law rises – Residents split on coverage mandate**

  Support for the Massachusetts universal health care law has increased since 2009, according to a poll of the state's residents — even as the law has become the subject of blistering attacks in national and presidential politics, and health care costs soar. The poll by the Harvard School of Public Health and The Boston Globe found that 63 percent of Massachusetts residents support the 2006 health law, up 10 percentage points in the past two years. Just 21 percent said they were against the law. Yet opposition has grown to one of its central elements — the requirement that people who can afford insurance buy it or face a fine. A similar provision in the national health care overhaul passed last year has been the subject of a contentious legal fight. Forty-four percent said they oppose the mandate in the Massachusetts law, compared with 35 percent who opposed it in a 2008 poll. Still, the mandate retains the support of a narrow 51 percent majority of residents. (Boston Globe)

- **Patrick names physician to lead Medicaid office, serving 1 million**

  Governor Deval Patrick plans this summer to bring onboard a practicing primary care physician to run state government's largest health care program. Patrick yesterday named Dr. Julian Harris, a former Rhodes scholar who practices at the Southern Jamaica Plain Community Health Center and works with Cambridge Health Alliance, as director of the Office of Medicaid, which provides insurance for more than 1 million children, families, seniors, and people with disabilities. Enrollment in the program has surged in recent years, largely due to the effects of the recession but also as a result of the state's 2006 health care access law. State officials are looking to pull $750 million in savings from the program next fiscal year, in part through procurement reforms, to balance the budget. (Boston Globe)

Oklahoma

- **Oklahoma second state to sign up for controversial health plan**

  Oklahoma is the second state to sign up for a conservative alternative to the federal health initiative - the Health Care Compact. Proponents say it is a more responsive, less bureaucratic alternative to President Barack Obama's health care initiatives. Opponents say it's a pipe dream that seeks to tinker with the nation's health care funding mechanism for political reasons. Last month Gov. Mary Fallin signed legislation to join the compact. So far, Georgia is the only other state to join. Several states are considering membership, including Texas and Missouri. (Tulsa Word)

South Carolina

- **State outlines plans for $125 million in new Medicaid cuts**

  The state Department of Health and Human Services announced Monday its plan to cut state Medicaid expenditures by $125 million. The 3 percent rate cut adopted in April for all providers will continue in fiscal 2012, resulting in additional savings of $38.6 million. The plan cuts $52.5 million in reimbursements, varying by provider with cuts of 2% to primary care, 3% to dental, and up to 7% for other providers. An additional $18.5 million in savings will be achieved through work with hospitals to reduce costs. (The State)

Texas

- **Senate passes health reform bill**

  The Texas Senate passed SB 7 by Sen. Jane Nelson (R-Lewisville), an omnibus health care reform and cost control bill. The bill is an amalgamation of SBs 7, 8, and 23 from the regular legislative session. The bill is non-controversial and passed unanimously. The bill has now been sent to the House for further action. The bill includes provisions such as the expansion of Medicaid managed care, utilization reviews of health care providers to ensure services are not being overused, financial penalties for Medicaid clients who show up in emergency rooms for non-emergency services, authorization to reduce payment for preventable medical errors, and payment based on health outcomes. The bill is a top priority for Lt. Gov. David Dewhurst. Medicaid is the state-federal program that pays for health care for the poor. (Lone Star Report)

United States

- **States slow to adopt health-care transition**

  As many legislatures around the country have finished their work for the year, fewer than one-fourth of states have taken concrete steps to create health insurance marketplaces, a central feature of the federal law to overhaul the U.S. health-care system. A total of 43 states, meanwhile, have made fresh cuts to Medicaid, even as lingering unemployment and diminishing access to private coverage continue to drive up the number of Americans turning to the public insurance program for the poor. (Washington Post)

- **Democrats stay quiet on Medicaid cutbacks**

  With intense budget negotiations on the debt limit under way, health care insiders think Democrats won't budge much on Medicare now that they have a significant campaign chip in their pockets: Kathy Hochul's upset win in New York's 26th Congressional District is Exhibit A of the power of Medicare. And that makes advocates worry that Medicaid cuts are more likely to come out of budget negotiations led by Vice President Biden. (Politico)

- **Medicaid To Stop Paying For Hospital Mistakes**

  Medicaid will stop paying for about two dozen "never events" in hospitals, such as operations on the wrong body part and certain surgical-site infections, federal officials said last week. Currently, about 21 states have such a nonpayment policy. The 2010 federal health law, in effect, expands the ban nationwide. The rule published last Wednesday gives states until July 2012 to implement it. Medicaid would save about $35 million over the next five years from stopping pay for such medical mistakes. Medicare has saved about $20 million a year under its policy. (Kaiser Health News)

PRIVATE COMPANY NEWS

- **CareMore**, the Downey, CA-based managed care company, will be bought by **WellPoint**, the nation's largest health insurance company, for about $800 million *Times*. CareMore is owned by private equity firm **CCMP**, which was formerly the private equity division of JP Morgan. (New York Times)

- **Vanguard Health Systems Inc.**, a Nashville, Tenn.-based hospital operator, has set its IPO terms to 25 million common shares being offered at between $21 and $23 per share. It would have an initial market cap of approximately $1.64 billion, were it to price at the high end of its range. Vanguard plans to trade on the NYSE under ticker symbol VHS, with BoA Merrill Lynch and Barclays Capital serving as co-lead underwriters. It and reports $1.6 million in net income for the nine months ending March 31, on nearly $3.4 billion in revenue. **The Blackstone Group** bought Vanguard in 2004 for approximately $1.75 billion. (Vanguard Health)

- **CIT Group Inc.** has led a $204 million credit facility to support refinancing of **Ernest Health**, the firm announced Friday. Ernest Health, which is backed by private equity firm **Ferrer Freeman & Co.**, is a provider of post-acute care services. **CIT Healthcare** served as sole bookrunner, joint lead arranger and administrative agent on the $150 million first lien debt, and as sole bookrunner and lead arranger on the $54 million second lien debt, the firm said in a written statement. Other terms of the deal were not disclosed. (Link to more)

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order. This week we added the timeline for the Massachusetts behavioral health RFP.

Date	State	Event	Beneficiaries
June 1, 2011	California ABD	Implementation	380,000
June 2, 2011	Massachusetts Behavioral	Vendor conference	386,000
June 24, 2011	Louisiana	Proposals due	892,000
June 24, 2011	Kentucky RBM	Contract awards	N/A
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey	Implementation	200,000
June 24, 2011	Kentucky RBM	Implementation	N/A
July 15, 2011	Washington	RFP Released	880,000
July 19, 2011	Massachusetts Behavioral	Proposals due	386,000
July 25, 2011	Louisiana	Contract awards	892,000
August 3, 2011	Washington	Bidder's conference	880,000
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
October 1, 2011	Arizona LTC	Implementation	25,000
July 19, 2011	Massachusetts Behavioral	Contract awards	386,000
October 17, 2011	Washington	Proposals due	880,000
December 19, 2011	Washington	Proposals due	880,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 1, 2012	New York LTC	Implementation	120,000
March 1, 2012	Texas	Implementation	3,200,000
October 3, 2011	Massachusetts Behavioral	Implementation	386,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000
January 1, 2015	Florida	DD RFP released	2,800,000
October 1, 2016	Florida	DD enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

States in Action: States' Role in Promoting Meaningful Use of Electronic Health Records

The Commonwealth Fund

Principal Renee Bostick provided the following update to The Commonwealth Fund's April/May 2011 newsletter, *States in Action:*

This issue of States in Action discusses the responsibilities, opportunities, and challenges for state Medicaid agencies in implementing programs to encourage providers to adopt electronic health records (EHRs). It focuses on the Medicaid Electronic Health Record Incentive Program, established by the Health Information Technology for Economic and Clinical Health (HITECH) Act in the American Recovery and Reinvestment Act of 2009

and jointly administered by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies. Rather than formal Snapshots of particular states' efforts, the issue includes lessons from states' early experiences in implementing the Medicaid EHR Incentive Program.

The EHR Incentive Program is just one of many health information technology (HIT) initiatives supported and encouraged by the federal government. With state Medicaid agencies facing competing demands as well as limited resources, states can benefit from aligning their efforts to promote health information technology, and collaborating with other agencies, states, and stakeholders to share or reduce costs, limit duplication, and avoid confusion for providers. (Link to Brief)

HMA Speaking Engagements

AcademyHealth's Annual Research Meeting 2011*: Topics in System and Payment Reform*

Dr. Jennifer Edwards, Principal

June 12-14, 2011

Seattle, Washington

National Hispanic Caucus of State Legislators – 'Promoting Healthy Lifestyles' conference: *Topic: Health Care Reform Financing at the State Level*

Juan Montanez, Principal

June 17, 2011

Miami, Florida