HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WE REVIEW THE NEW YORK EXCHANGE BILL PROPOSED BY GOV. CUOMO

HMA ROUNDUP: FLORIDA MEDICAID MANAGED CARE STAKEHOLDER MEETINGS BEGIN; GEORGIA OFFICIALS TO DISCUSS INSURANCE EXCHANGES; STATE TAX RECEIPTS IMPROVE IN MICHIGAN AND GEORGIA; CMS REVIEWING NEW JERSEY WAIVER

OTHER HEADLINES: MEDICAID CUTS IN CALIFORNIA, COLORADO, MONTANA THREATEN ELDERLY AND DISABLED CARE; KANSAS ANNOUNCES PUBLIC HEARINGS ON MEDICAID OVERHAUL; KENTUCKY AND LOUISIANA LAWMAKERS QUESTION MCO EXPANSIONS; REPUBLICANS, DEMOCRATS AT ODDS OVER FEDERAL MEDICAID ELIGIBILITY RULES

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JUNE 15, 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: NEW YORK GOVERNOR'S EXCHANGE BILL

This week, our *In Focus* section looks at *Program Bill #12*, an act to establish the New York Health Benefit Exchange in accordance with the Affordable Care Act (ACA), released by Governor Cuomo's office on Monday, June 13. The Governor's bill is intended to fulfill the federal requirement that states establish a state-based Health Benefits Exchange. In absence of state action, an exchange will be established by the federal government. A memorandum from the Governor's office accompanying the bill argues that it is critical that New York design and implement its own exchange because of the unique population, regional variability in individual and small business insurance markets, and the seamless integration required with the Medicaid program, which covers higher-income populations than a majority of states. Further, the bill urges timely action to take full advantage of federal funding initiatives for Exchange design and establishment.

The Governor's bill would create a single Exchange for individuals and small-group purchasers of qualified health plans. The Exchange facilitates eligibility and subsidy determinations for people applying for Exchange coverage, as well as facilitating enrollment in Medicaid or other public health coverage programs if an applicant is determined to be eligible for those programs. The Exchange will be established as a public benefit corporation managed by a board of directors. Below, we outline the major structural components of the Exchange as laid out by the Governor's bill. Additionally, we highlight the six key decision points the state must make within a rigid timeline to meet the goals of the ACA. One key decision that has been left to the discretion of the Exchange Board is whether or not the state will actively select health plans to participate in the exchange or if it will allow all interested plans to participate. Clearly, a decision to limit the number of plans participating, and the criteria used to evaluate the options, would have significant implications for the marketplace and is likely to be opposed by the managed care industry.

Exchange Framework

- The Exchange, as a public benefit corporation, will be managed by a board of directors consisting of the Superintendent of Insurance, Commissioner of Health, and the state Medicaid Director. Four additional directors will be appointed by the Governor.
- The Exchange will make available qualified health plans and certain qualified dental plans to qualified individuals and employers on or before January 1, 2014.
- In accordance with the ACA, the Exchange will assign ratings to qualified health plans, utilize a standardized format for presenting health benefit options, and require that qualified health plans offer "essential benefits" to be determined by the federal HHS Secretary.
- The Board of Directors will establish enrollment periods consistent with state insurance law, unless in direct conflict with the ACA. An insurer will be required to meet minimum requirements to be considered for participation for the Exchange.

- The Board will decide whether to allow all health plans to participate or instead selectively contract with only a limited number of plans. These contracting decisions will be guided by the principles of choice, value, quality and service.
- The Exchange will include an website though which enrollees and prospective enrollees can obtain standardized comparative information on available plans. Additionally, there will be an electronic "calculator" to determine actual cost of coverage for individuals, factoring in premium tax credits and subsidies.
- The Exchange will have the ability to inform prospective or current enrollees of their eligibility for the state's public health insurance programs, including Medicaid, Child Health Plus, Family Health Plus and Healthy NY, and if eligible, enrolling them in such programs.
- The state will establish a Small Business Health Options Program, or SHOP, through which qualified employers may gain access to health insurance coverage for their employees.

Key Decisions Timeline

- **July 1, 2012:** Compare essential benefits identified by the HHS Secretary to the benefits mandated by state law. Recommend whether any or all state-mandated benefits should be offered through the Exchange at state expense.
- **July 1, 2012:** Consider whether insurers participating in the Exchange must offer all health plans sold in the Exchange to individuals outside of the Exchange. Consider how to develop and implement the transitional reinsurance program required by the ACA. Consider whether to merge the individual and small-group health insurance markets for rating purposes.
- **July 1, 2012:** Make recommendations regarding the basic health plan program. Make recommendations regarding the funding and self-sufficiency of the Exchange. Make recommendations regarding benchmark benefits. Make recommendations on the role of licensed health insurance agents and brokers in the Exchange.
- **July 1, 2012:** Make recommendations on the impact of the Exchange on the Healthy NY and Family Health Plus employer partnership programs.
- **July 1, 2012:** Make recommendations on whether and to what extent health savings accounts should be offered through the Exchange.
- **December 1, 2016:** Recommend whether to allow large employers (those with 100 or more employees) to participate in the Exchange beginning January 1, 2017.

Senate Exchange Bill

The New York State Senate has also introduced legislation that begins the process of establishing the Exchange in New York. The Senate bill (S5652) does not appear to be as fully developed as the Governor's proposed bill. It is possible, however, that significant portions of the Governor's bill will be integrated into the Senate bill in the legislative pro-

cess. It appears to be the desire of Governor Cuomo to move swiftly in enacting Exchange legislation, so we will continue to watch the process closely as it develops over the coming months.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

While the Senate last week passed minor elements of the Governor's revised budget (with the House rumored to vote soon), the key sticking point of the budget remains the proposed extension of current taxes. The Controller's office has said that legislators will have their per diem salaries withheld until a budget is passed.

The proposed elimination of the Healthy Families program remains controversial and is opposed by the Medi-Cal health plans. A study of the Healthy Families program has been proposed in the current budget legislation, and it is possible that the study will outline a methodology by which the program is eliminated and fully transitioned to Medi-Cal.

In the news

- **In California, adult day care program is threatened with extinction**
  The state of California chose earlier this year to cut Medicaid funding for adult day health care centers to save money in the current budget. Without Medicaid funding — $170 million from the state, plus an equal amount from the federal government — most of the centers will find it difficult to stay open. The 39,000 elders and adults with disabilities who spend their days at the centers — receiving medical treatment for chronic diseases, as well as mental health counseling and physical therapy — will have to find somewhere else to go. The state says it will find other Medicaid services for the patients, but elder advocates say there are no other facilities that provide the same kind of care. Many patients will end up calling emergency medical services, going to emergency rooms and getting admitted and re-admitted to hospitals. Some will go directly to nursing homes. Instead of paying $76 per day for adult health care, the state will have to reimburse nursing homes at a rate of $200 per day. (Stateline)

Florida

HMA Roundup – Gary Crayton

The Agency for Health Care Administration (AHCA) conducted their first of 11 regional meetings on the statewide Medicaid managed care expansion last Friday in Tallahassee. The 10 remaining meetings are occurring throughout this week and next. A copy of the presentation slides is available here: (Link to Presentation). The majority of testimony and public comment at the Tallahassee meeting focused on concerns with the planned managed care expansion.

After public meetings have concluded, the state will submit a waiver and any additional changes needed by August 1, 2011. To our knowledge, the current waiver, set to expire on June 30, has not been extended..

Georgia

HMA Roundup – Mark Trail

Several members of the Governor's Exchange committee met unofficially last week. Official meetings should begin in the coming weeks, with meeting agendas and minutes made available to the public through open meetings requirements.

The Governor and Legislature have indicated that increased May revenue projections will most likely be used to rebuild depleted rainy day funds

Illinois

HMA Roundup – Jane Longo / Matt Powers

Both the House and Senate have passed a budget, which now awaits Governor Quinn's signature.

In the news

- **Illinois takes slow approach on health exchange**

  The Illinois Legislature during its just-finished session formed a bipartisan committee to study how an insurance exchange should be set up, taking a step back from a detailed plan that evolved from a task force formed by Gov. Pat Quinn. While Illinois joined a handful of states passing legislation to set up insurance exchanges, the bill that passed last week won out over a proposal for a more ambitious approach. That bill died without coming to a vote, along with another bill that would have given state regulators power to deny health insurance rate increases. (Daily Herald)

Massachusetts

HMA Roundup – Tom Dehner

Centene's CeltiCare extended their statewide contract under the Commonwealth Care Bridge program.

The Accountable Care Organization (ACO) request for information (RFI), issued two weeks ago, is due July 13, at which time all comments will be made public.

In the news

- **Immigrant health care back in court**

  Thousands of legal immigrants may have to wait weeks longer to find out whether the state's highest court will order Massachusetts to restore their full health insurance benefits. Massachusetts Supreme Judicial Court Associate Justice Robert J. Cordy today ordered lawyers for the state to file their motions by June 23. (Boston Globe) Centene Corporation announced last week it has extended its statewide contract to serve Commonwealth Care Bridge Program members, effective July 1, 2011. Under the contract,

CeltiCare will continue to be the sole provider of high quality health insurance to Massachusetts residents enrolled in the Commonwealth Care Bridge Program, which serves the state's legal immigrant population of roughly 26,000 lives. (Press Release)

Michigan

HMA Roundup – Esther Reagan

May revenues beat projections, but officials are cautioning that any economic improvement is still fragile.

New Jersey

HMA Roundup – Eliot Fishman

New Jersey has now released a breakout of projected budget impacts from its Section 1115 Waiver proposal. State Department of Human Services officials have also revealed some initial CMS responses to the waiver in a recent public meeting.

First, a significant proportion of the headline $300 million savings projection associated with the waiver—approximately 35%--appears to be attributed to New Jersey's request for relief from retroactive Medicare Part B costs erroneously paid by Medicaid. Several states, including NJ, have proposed that CMS allow states to deduct their requested retroactive Part B from 1115 waiver expenditures as a way to grant relief for this long-running federal-state dispute The final disposition of this request will be negotiated on behalf of a number of states.

Second, New Jersey has clarified the status of its proposal to freeze indefinitely enrollment of all parents above TANF income levels, 25% of FPL. Although these parents are covered under a Title XXI SCHIP Waiver, New Jersey has stated its understanding that they are still subject to the Medicaid Maintenance of Effort requirements in the Affordable Care Act. As a result, CMS would need to grant New Jersey a waiver from these MOE requirements to enable enrollment for parents to be frozen. We don't believe such a waiver is likely.

Third, New Jersey had proposed to require dual eligibles to enroll in a single Medicaid HMO/Medicare SNP as part of its implementation of comprehensive managed acute and long-term care for dual eligibles. New Jersey requested the authority to auto-assign enrollees to a combined plan with the ability to opt out of Medicare. New Jersey officials have indicated that CMS ruled this request to be a non-starter, and they are now discussing ways to encourage MA SNP enrollment for duals in a formally voluntary framework. It is not clear whether CMS has made a general policy determination against mandatory integrated MCO enrollment for duals or if this decision was made due to New Jersey specific factors.

Other elements of the waiver are moving forward on an aggressive timetable. Managed long-term care has already been partly implemented via addition of personal care and adult day benefits to existing managed care contracts, which will be completed as of August 1st. The state is seeking a 10-1-11 start date for the approved elements of the waiver,

including full implementation of mandatory managed long-term care beginning at that time and to be completed at the outset of (or early in) calendar year 2012.

In the news

- **Christie proposal to slash Medicaid by $540 million puts NJ at center of national debate**
  At issue in New Jersey is a $540 million cut to state Medicaid funding that Gov. Chris Christie proposed for next year's budget. About $240 million comes from specific program cuts, such as $140 million dropped from nursing home coverage. Christie hopes to save $300 million through a "comprehensive Medicaid waiver." States submit waivers to the federal government requesting permission to restructure their program outside the core parameters for what they must cover. (Washington Post)
- **Human Services officials release details on N.J. Medicaid program cuts, changes**
  The Christie administration released a long-anticipated outline today of how the state proposes to drastically restructure New Jersey's Medicaid program and cut more than $300 million to help close a deficit. In the most controversial element of the proposal, the Department of Human Services expects to save as much as $32.5 million by sharply limiting who is eligible for coverage. It was the first time that the state disclosed estimates of what each change would save. For instance, parents in a family of three earning more than $422 a month, or $5,000 a year, would be disqualified for earning too much money, according to a document summarizing the proposal. Currently the income cut-off is $24,600 for a family of three. (NJ.com)

Texas

HMA Roundup – Dianne Longley

Texas legislatures are currently tackling the Fiscal Matters Bill, of which the major sticking point remains the allocation of education funding. The bill has been passed between the House and Senate with numerous amendments.

Senate Bill 7 is also be reconsidered by the Senate after House amendments. The bill approves Medicaid cost savings as well as the managed care expansion in South Texas. Additionally, the bill would add Texas to the few states who have passed legislation to join an Interstate Health Compact.

In the news

- **House OKs Bill to Seek Federal Medicaid Waiver**
  The Texas House passed a bill today to take control of Texas health care reform. Representatives tentatively passed HB 13, a special session bill that will allow Texas to petition the Obama administration for a block grant to operate the Medicaid program. (Texas Tribune)
- **Perry Rejects "Obamacare," but State Agency Pushes On**
  Republican Gov. Rick Perry has made no secret of his disdain for federal health reform, or for one of its key tenets, a Travelocity-like state insurance marketplace in which con-

sumers could choose from public and private health plans. Meanwhile, despite Perry's stated opposition to a health insurance exchange, and the state's participation in lawsuits aimed at overturning federal health reform, officials at Texas' Department of Insurance acknowledge that since last fall, with the help of a $1 million grant from the U.S. Department of Health and Human Services, they have been working behind the scenes to plan for a health insurance exchange. (Texas Tribune)

OTHER HEADLINES

Colorado

- **Planned cuts to Department of Human Services could sever lifeline for disabled**
  A proposed deep cut in state spending for developmentally disabled and autistic clients has parents and providers scrambling to block a move they say would shatter carefully built networks of care. Legislators demanded that state human-services officials reverse fast-growing spending for behavior therapy, day programs, dental care and other services, prompting $8 million in spending cuts for the group in the budget year starting July 1. The paring will begin in October unless parents and providers persuade Department of Human Services officials to change the plan. Opponents say it will not only decimate care for a severely troubled population but will end up costing various governments more money through increases in emergency-room visits, hospitalizations and other social costs. (Denver Post)

Kansas

- **Brownback announces public forums for input on Medicaid overhaul**
  An overhaul by Gov. Sam Brownback of the $2.8 billion taxpayer-funded Medicaid program is in the works. On Monday, Brownback's point man on the effort, Lt. Gov. Jeff Colyer, announced there will be three public forums on Medicaid, the first being next week in Topeka. (LJWorld.com)

Kentucky

- **Merger creates Kentucky's largest health group**
  Three organizations announced a merger Tuesday that will create Kentucky's largest health care system but is effectively controlled by an out-of-state organization. The new system, which hasn't been given a name, will combine University Hospital and the University of Louisville's James Graham Brown Cancer Center, Jewish Hospital & St. Mary's HealthCare, and St. Joseph Health System based in Lexington. Catholic Health Initiatives, the Denver-based parent of St. Joseph Health and a partner in Jewish Hospital & St. Mary's, will appoint 10 of the 18 members of the new organization's board of directors in return for injecting $620 million into the system. Some of that money will be used to expand medical training programs at U of L and target health concerns statewide. (Courier-Journal)
- **Lawmakers question state's readiness for Medicaid managed care**

State lawmakers Thursday questioned whether the state has the resources and expertise to oversee moving the $6 billion Medicaid program to private, for-profit managed care companies. Committee staff reviewed three different committee reports from 2004 to 2007 to determine whether any of the recommendations had been followed. They found the state Medicaid staff did not perform enough analysis to determine whether there were savings in the current program and the staff has not been rigorous in monitoring waste, fraud and abuse. But cabinet officials, in a response to the report and in testimony Thursday, told state lawmakers they believe they have the expertise to negotiate managed care contracts. They will step up monitoring once those contracts are in place, officials said. The cabinet told the legislature earlier this year it planned on having the contracts signed on July 1, but did not say the switch would be complete by July 1. (Kentucky.com)

Louisiana

- **Gov. Bobby Jindal's Medicaid privatization plan rejected by Louisiana House panel**
  The Louisiana Legislature is nearing a final vote on a bill that eventually would give lawmakers the power to scrap Gov. Bobby Jindal's planned privatization of the state's Medicaid insurance program for the indigent and working poor. The proposal, which cleared the House Health and Welfare Committee on a series of divided votes Tuesday, represents legislative displeasure at the governor's seeking of an overhaul of the multi-billion-dollar enterprise without lawmakers' input. Gov. Jindal is likely to veto the measure. (NOLA.com)

Montana

- **Assisted-living facilities getting 10% cut in Medicaid payments**
  If the Schweitzer administration cuts Medicaid payment rates as planned, one group of health care providers in Montana will see a 10 percent cut, rather than 2 percent: Assisted-living centers. About 800 elderly and disabled people in Montana are in assisted-living homes and covered by Medicaid, the state-federal program that pays medical and health-related bills for the poor. Owners and operators of assisted-living homes are saying that if the 10 percent cut goes forward, they'll probably stop accepting Medicaid-covered patients, who then likely will end up in more expensive nursing homes. (Billings Gazette)

New Mexico

- **Hearing on Medicaid hints at conflict to come**
  The Martinez administration's plans to overhaul Medicaid have provoked concern, even fear, among New Mexico's health care advocates and some of the program's recipients. And that anxiety was evident at Tuesday's hearing. While details of the redesign were scarce Tuesday, the administration did enumerate some of the principles that would guide the state's effort to overhaul Medicaid over the next 24 months: (1) Increase Medicaid recipients' personal responsibility by imposing copays for some high-cost services but also rewarding good behavior, such as a recipient's decision to quit smoking; (2) Put into place pay-for-performance targets that encourage better health

care outcomes than paying for the quantity of services a provider gives. (3) Ask the federal government for a "global waiver" to get rid of some of the bureaucratic layers in New Mexico's current Medicaid program. (Santa Fe New Mexican)

North Dakota

- **ND lawmakers crafting health exchange bill**
  Encouraged by a former federal health and human services secretary, a group of North Dakota lawmakers agreed Tuesday to support drafting legislation to broaden health insurance coverage in the state. The Legislature's interim Health Care Reform Review Committee will be preparing the measure for possible introduction during a special legislative session in November. The proposed bill would establish a North Dakota health insurance exchange. Several states are setting up the exchanges, which are included in the new federal health care law. They are intended to promote competition among health insurance companies and give customers several plans to choose from. (Westport News)

United States

- **GOP governors push back against Obama on federal Medicaid rules**
  Faced with severe budget problems, Republican governors are escalating their fight against federal rules requiring states to maintain current levels of health-care coverage for the poor and disabled. The growing resistance to the federal government over the hugely expensive Medicaid program poses a critical test for President Obama, who has the power to relax the rules for states. If he allows states to tighten eligibility requirements, it would outrage many of his core supporters while undermining the central goal of his signature health-care law: expanding health insurance coverage. But if the president turns his back on governors struggling to gain control of their finances by trimming their most costly program, he risks intense criticism just as his administration is locked in a battle with Republicans over the nation's soaring debt. (Washington Post)
- **ISSUE BRIEF: Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide**
  In many states, Medicaid programs have contracted out the delivery of health care services to publicly traded health plans that are focused on managing the care of Medicaid members. Under the health reform law, states will be expanding the enrollment of their Medicaid programs and these publicly traded companies are expected to capitalize on this growing market. This study examined how publicly traded health plans differ from non–publicly traded ones in terms of administrative expenses, quality of care, and financial stability and found publicly traded plans that focused primarily on Medicaid enrollees paid out the lowest percentage of their Medicaid premium revenues in medical expenses and reported the highest percentage in administrative expenses across different types of health plans. The publicly traded plans also received lower scores for quality-of- care measures related to preventive care, treatment of chronic conditions, members' access to care, and customer service. (Commonwealth Fund - PDF)
- **Moving Beyond Fee-For-Service: The Case for Managed Care in Medicaid**

From the American Action Forum: *"Fee-for-service (FFS) reimbursement is at the heart of what is wrong with the Medicaid program. By underpaying providers for uncoordinated care, FFS has impaired patient access, led to lower quality outcomes, and hampered efforts to instill greater program accountability. This paper makes the case for moving to managed care in Medicaid to deliver more consistent and higher quality care."* (American Action Forum)

- **Senate Democrats tell Barack Obama to reject Republican Medicaid proposals**
  Forty-one Senate Democrats are urging President Barack Obama to reject GOP proposals to dramatically change Medicaid, marking the party's strongest defense yet of the federal-state health care program. The clear message: Medicaid block grants or other caps on federal Medicaid spending cannot get through the Senate. While Democrats have rallied against the Republican plan to transform Medicare into a voucher-like program, they had so far presented a less united front on a GOP proposal to block-grant Medicaid, which would cut more than $750 billion from the program over the next 10 years. With pressure on both sides to enact entitlement reforms in ongoing debt-limit negotiations, advocates have been concerned that Medicaid would be more vulnerable to cuts now that Democrats believe they have a major political advantage on Medicare. (Politico)

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 time-line 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
October 3, 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
March 1, 2012	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

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