HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: DETAILED REVIEW OF LOUISIANA MANAGED CARE RFP BIDDER SCORES

HMA ROUNDUP: ILLINOIS OUTLINES COORDINATED CARE PLAN; FLORIDA HOSPITAL RATE REVIEW PROCESS CONTINUES

OTHER HEADLINES: MEDICAID, MEDICARE CUTS OFF THE TABLE IN DEFICIT TALKS; CALIFORNIA GOV. VETOES ADULT DAY HEALTH REPLACEMENT; NEW YORK HOME HEALTH CUTS DRAW CRITICISM; PASSPORT TO REPAY $26M TO KENTUCKY MEDICAID; LOUISIANA ISSUE BEHAVIORAL HEALTH RFP; FEDS TO REVIEW INSURANCE RATE INCREASES

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JULY 27, 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: DETAILED REVIEW OF LOUISIANA MANAGED CARE RFP BIDDER SCORES

This week, our *In Focus* section reviews the Medicaid managed care contract awards for Louisiana's Coordinated Care Network (CCN) RFP that were announced on Monday, July 25, 2011. Centene, AmeriHealth and Amerigroup were awarded contracts, with Centene the highest scoring bidder. We review the award evaluations and some key takeaways from the evaluation scoring, as well as highlight determining factors for each plan.

Overview

The state released RFPs in early April 2011 for the CCN program, which will replace the state's existing CommunityCARE PCCM program and will offer roughly 875,000 beneficiaries the choice of delivery system models between:

- FFS/PCCM with shared savings (CCN-S); or
- Prepaid risk-bearing managed care organizations (CCN-P)

We estimate the total contract awards at roughly $1.8 billion in annual revenue. Previously, we provided a full review of the RFP in the April 13, 2011 Weekly Roundup. Below we provide a few key points on the structure of the RFP:

- Enrollment is divided into nine regions, grouped into three geographic service areas (GSAs).
- Enrollment in each GSA will range from roughly 255,000 to 317,000 beneficiaries.
- Each GSA will be served by three CCN-Prepaid plans.
- CCN-Prepaid and CCN-Shared Savings plans will be treated equally for purposes of auto-assignment. Members not auto-assigned based on provider preference will be evenly distributed across all of the plans in each GSA.
- Pharmacy services are carved out of the managed care benefit package and will remain as a FFS benefit while most mental health services are carved in.
- We note that there is no cost component in the RFP scoring criteria.
- The RFP mandated a minimum 85% MLR.

Key Takeaways

Centene the highest scoring bidder

A striking observation from the award evaluation scores is the margin by which Centene (Louisiana Healthcare Connections) outscored the other bidders. Out of a possibly 1,900 points, Centene scored roughly 1,800 in all three GSAs. AmeriHealth was the next closest at just under 1,700. In fact, four bidders – AmeriHealth, Amerigroup, Coventry, and Aetna – all finished within 100 points of each other. WellCare was the decisive loser in

all three GSAs, scoring at least 90 points below AmeriHealth, Amerigroup, Coventry, and Aetna, and more than 200 points below Centene. United bid on only one GSA, finishing just behind the third-scoring bidder, Amerigroup.

	GSA "A"	GSA "B"	GSA "C"	Average
Centene	1,803	1,803	1,799	1,802
AmeriHealth	1,697	1,693	1,690	1,693
Amerigroup	1,675	1,672	1,668	1,671
United	*No Bid*	*No Bid*	1,657	1,657
Coventry	1,646	1,629	1,632	1,635
Aetna	1,636	1,635	1,630	1,633
WellCare	1,540	1,537	1,534	1,537

"Value Added to Louisiana" a major factor

A key factor in Centene's high score was a perfect score of 200 points on a section of the RFP titled, "Value Added to Louisiana." The sectioned pertained to provider incentives payments and additional benefits to clients. Centene's bid includes more than $535,000 in monthly added value, with more than $260,000 in monthly provider incentive payments, and nearly $275,000 in additional benefits to clients. To contrast, WellCare offered roughly $90,000 in monthly added value, with $50,000 in provider incentive payments and $40,000 in additional benefits, receiving only 34 of 200 possible points. Second-place AmeriHealth offered roughly $340,00 in monthly added value payments and benefits, receiving 125 out of 200 points. This section appears to be a significant driver of scoring differential between bidders, and certainly accounts heavily for Centene's margin in scoring.

	Provider Incentive Payments	Additional Benefits to Clients
Centene	$260,925	$274,575
AmeriHealth	$129,000	$209,250
United	$112,500	$176,250
Coventry	$106,500	$141,150
Aetna	$127,125	$61,500
Amerigroup	$132,750	$18,000
WellCare	$49,950	$40,500

All added value payments and benefits must remain in place at their current level for 36 months, although provider incentive payments may be increased and additional benefits may be expanded. Provider incentive payments beyond the base Medicaid reimbursement floor must be paid to all providers in the CCN network and not negotiated with a subset of providers. Additional benefits to clients include services not covered under the Louisiana state Medicaid plan, or benefits that go beyond the amount, scope, or duration as limited by the state Medicaid plan. We note that RFP scores did not detail how provider incentive payments or additional member benefits will be structure. We expect this

to be revealed in final contracts between the state and plans. Additionally, the RFP requested that plans demonstrate how the additional benefits will be sustainable for a 36-month contract period.

WellCare score brought down by breach of contract, sanctions, investigations

Section B of the proposals details qualifications and experience of the plan, with significant opportunity for negative points. This was the case for WellCare, losing nearly 100 points for breach of contract, sanctions, litigation, and investigations. These related to the Florida BH investigation, Medicare Advantage marketing sanctions, and other issues. Combined with the value added section, it appears that these were the drivers of WellCare's below-average scoring.

United and Community win CCN Shared Savings bids, but scores lower

United and Community were awarded bids in the CCN Shared Savings plan, although we note that scores appeared lower than under the CCN Prepaid bidding, despite a lower potential point total. Additionally, Louisiana Physicians Connections - a new local plan based in Baton Rouge - bid on all three GSAs, but was not awarded a bid in any of the three.

In the following sections, we highlight some of the key factors in each plan's bid that separated them as a winner or loser.

Awarded

Centene

Clearly Centene's high value added payments and benefits are a driver of its high-scoring bid. By scoring well elsewhere in the proposal, at least in line with AmeriHealth, Amerigroup and others, this provided the differentiating factor in their overall score, giving Centene a 75 point advantage over AmeriHealth and a 140 points advantage over Amerigroup.

AmeriHealth

Although scoring slightly lower than Amerigroup in several categories, including the provider network, customer service, and information systems sections, AmeriHealth's strong score in the value added payments and benefits section held them score above Amerigroup.

Amerigroup

Amerigroup scored very well on the majority of the proposal, but lost over 140 points on the value added payments and benefits section, offering more than $132,000 in monthly provider incentive payments, but only $18,000 in added benefits . A perfect score in that category would have placed Amerigroup ahead of Centene in overall scoring.

Not Awarded

United

United bid only on GSA "C" and scored well, aside from some lost points due to regulatory action, predominantly in Tennessee, as well as failing to address how they will provide tertiary care centers in their network. United scored well in the value added payments and benefits section and fell just over 10 points behind Amerigoup for the third place spot in GSA "C". Additionally, we note that United bid on all three GSAs as a CCN Shared Savings plan and won in all three as the highest bidder.

Coventry

Coventry lost significant points in the section pertaining to project planning for excluding a work plan. This appears to be the only significant scoring component separating Coventry from Amerigroup, although Coventry scored better in the value added payments and benefits section.

Aetna

Aetna scored relatively well aside from the qualifications and experience section. Points were lost for failure to respond to breach of contract section, as well as 32 instances of regulatory action in 2010 for out-of-network policies and prompt pay issues. We also note that Aetna lost 15 of 75 points on a section requiring the listing of all other managed care contracts for having limited Medicaid contracts and mostly Medicare and Commercial managed care contracts.

WellCare

As mentioned above, WellCare was severely docked on points for breach of contract, sanctions, litigation, and investigations. This includes:

- Submitted 19 pages in RFP response of reported litigation, as well as a 2007 SEC investigation into accuracy of company financial filings, which we believe is related to the Florida behavioral health investigation,
- submitted 45 pages in RFP response of reported regulatory action, including HIPAA violations, US criminal and civil investigations, and failure to file financial statements,
- a 2009 breach of contract with CMS for several months related to the Medicare Advantage marketing sanctions, and
- a 2007 settlement with the South Carolina not to participate in the state's Medicaid managed care program for three years.

Additionally, WellCare's low value added payments and benefits played a significant role in their low overall score. As noted above, cost was not a consideration in scoring RFP responses.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Gary Crayton / Elaine Peters

The Florida Agency for Health Care Administration (AHCA) posted the new Florida hospital rates on Friday, July 15 for 2011-12 (available here). The managed care legislation passed earlier this year (HB 7109) revised the hospital rates from being established twice a year (January 1st & July 1st) to once a year (July 1st of each year). Hospitals can submit data for rate-setting revisions through September 30, 2011, when rates will be locked in for the coming year.

For most hospitals, the rates as set are likely to be accurate and will not change. However, for the subset of hospitals with the ability to "buy back" their reduction to exemptions above the base rate, or add-on payments, the rates are likely to revise upwards by September 30. This subset of hospitals is also responsible for roughly 75% of all Medicaid days in the state. When rate calculations are finalized, any rate adjustment must be factored into the managed care plan capitation rates. For this reason, it is likely that AHCA will extend the deadline for rate revisions if it was necessary to achieve greater accuracy in rate-setting.

In the news

- **Health plan a huge problem for Jackson Health System**

  The JMH Health Plan, the insurance wing of the Jackson Health System, has become a huge money-loser that must be fixed quickly, board members were told Thursday. So far this year, the plan has lost $30.4 million — almost half of the $71.7 million that Jackson Health System has lost for the entire fiscal year. Previous administrations had counted on the health plan as a major money-maker to compensate for all the uninsured patients. But with $337 million in system losses the past two years, deficits in the insurance plan seem an unconscionable drain, board members concluded. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The state is in the process of reconciling potential duplicate enrollees in managed care plans. Additional information is due this week or next, but is likely to have significant implications regarding the recovery of duplicated payments to plans.

As noted last week, the next Governor's Exchange Committee meeting is set for August 16, 2011.

In the news

- **New Grady CEO faces financial, political hurdles**

  From gearing up for the health care overhaul to dealing with rising numbers of uninsured patients, John Haupert will confront an array of hurdles as Grady Health Sys-

tem's new chief executive officer. In 2009, Grady turned its first profit in years after business and community leaders joined together to save it from financial collapse. The hospital, which spends more than $200 million caring for the uninsured, has recently faced several setbacks, however, including a $20 million cut in local and federal dollars. Officials have cut more than 200 jobs, as well as upped prescription drug co-pays and shut down two neighborhood clinics this year. Grady saw an $18 million shortfall in the first six months of 2011. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The state has presented a care coordination plan and timeline for the implementation of the Medicaid reform law requiring 50% of the Medicaid population to be enrolled in a care coordination program by January 1, 2015. Below are several key points from the plan:

- ACA will make roughly 700,000 uninsured individuals newly eligible for Medicaid. The state expects all of these applicants to enroll with care coordination entities.
- During FY2012, the state will develop a Phase I Innovations Project to test alternative models of care, not including traditional HMOs, to serve children and families, special populations, and seniors and persons with disabilities. The state will solicit proposals, with solicitation process announcements due by the end of the year. Awards would be announced in Summer 2012, allowing time for proposal submission, evaluation, and development of federal waivers and state plan amendments, as necessary.
- The solicitation process for Phase II is expected to begin in mid-2012 to increase care coordination on a much larger scale, and is likely to include traditional managed care plans alongside other models of care.
- The plan cautions that prior to Phase II implementation on a large scale, hospital rate reform must be accomplished to allow for large-scale risk and managed care coordination.

Indiana

HMA Roundup – Cathy Rudd

Enrollment will be opened for an additional 8,000 individuals on the waiting list for the Healthy Indiana Plan. The open enrollment is expected fill all open 8,000 spots for childless adults. However, a significant waiting list will remain.

OTHER HEADLINES

California

- **Brown vetoes replacement for senior care cut from budget**

  Gov. Jerry Brown riled advocates for the elderly and disabled on Monday with an announcement that he vetoed legislation to create a replacement program for senior care services scrapped as part of this year's budget agreement. Assembly Bill 96 would have allowed roughly half of the state's 300 Adult Day Health Care centers to continue to operate under a new, federally approved program. It was approved in response to an agreement to ax the Adult Day Health Care services to cut state spending. (Sacramento Bee)

- **Medicaid Waiver Good News for L.A.'s Homeless**

  There is some hope that national health care reform and California's Medicaid waiver -- known as the Bridge to Reform -- may help make it easier for government agents and agencies to provide health care and housing for the homeless. The waiver allows the state to expand Medicaid income eligibility up to 133% of the federal poverty level for uninsured county residents ages 19 to 64. The waiver also will help increase provider payments for uncompensated care, which could have a significant impact on care for the homeless. The waiver also authorized mandatory, phased-in enrollment over 12 months of vulnerable populations, seniors and persons with disabilities into managed care plans. That process began July 1. Community clinics will play an important role in disseminating information about enrollment and completing the process. (California Health Line)

Colorado

- **Colorado nonprofit's planned sale of share in hospitals to HCA raises doubts**

  The Colorado Health Foundation has no guarantee that medical giant HCA will keep open all of its hospitals after the foundation's $1.45 billion sale of its share of their joint venture, and the board is still bargaining for assurances that HCA will continue Medicaid care in the state's largest hospital system, documents show. The preliminary sale agreement, currently under review by the state attorney general, guarantees a large doctor residency program for five years, rather than the indefinite continuation urged by some medical leaders. Foundation officials note in response that the current pact with HCA allows either side to cancel the graduate medical-education agreement in any year. (Denver Post)

Idaho

- **After Idaho Dental Cuts, the Pain Runs Deep**

  The state's cost-saving Medicaid reform passed earlier this year left more than 42,000 Idahoans under Medicaid without non-emergency dental coverage. The dental program cuts - part of larger, $34 million reform-based savings - are estimated to save the state $1.7 million from the general fund and $3.9 million in federal funds. The cuts will only affect adults over the age of 21. Children and pregnant women will continue to receive Medicaid-provided dental services. (Times News Magic Valley)

Kentucky

- **Conway negotiates Passport repayment to Medicaid**

  The attorney general's office has found payouts from a Louisville-area Medicaid plan manager to health care providers violated state law and has ordered $26.4 million to be repaid. The money came from surplus Passport funds in 2008 and 2009 and was paid to health providers on Passport's board. A nonprofit corporation such as Passport cannot under state and federal law pay cash dividends to members. Passport provides health care for about 165,000 low-income and disabled Medicaid patients in Jefferson and 15 surrounding counties under a $740 million annual contract with the state. (New England Cable News)

Louisiana

- **Private company to take over care**

  The state is preparing to turn over to a private company the management and coordination of behavioral health care for more than 150,000 children and adults. The state Department of Health and Hospitals' efforts are geared to about 2,500 children and youth at-risk of jail or other institutional placement because of serious mental health issues, addictive disorders or both. Now, DHH has issued a "request for proposals" for a private firm to handle that population, as well as another 50,000 children and youth and 100,000 adults with behavioral health issues. Companies have until Aug. 15 to submit their credentials and their recommendations for how to run a "State Management Organization," called SMO. The state budget for the fiscal year that began July 1 appropriates $167.5 million for behavioral health programs, including $12 million for transition and training related to the move. (The Advocate)

Minnesota

- **HMOs to feel pinch in new Minnesota health budget**

  Minnesota's new two-year budget contains some tough medicine for nonprofit health plans that manage subsidized care for more than 500,000 poor patients. The health and welfare spending bill signed into law earlier this week by Gov. Mark Dayton cuts or delays $435 million in payments to HMOs, which together have state contracts worth about $3 billion this year. The HMO cuts account for more than two-fifths of the spending reductions for health and welfare programs. The reductions were part of a budget deal that ended a 20-day government shutdown, the nation's longest in at least a decade. (Forbes)

New Hampshire

- **10 hospitals sue NH over Medicaid funding**

  Ten hospitals sued New Hampshire in federal court Monday over the state's payments to them for caring for Medicaid patients, claiming the inadequate reimbursement is jeopardizing the poor's access to health care. The hospitals argue the state made deep cuts to their reimbursement for budgetary reasons, not out of consideration of what amount was needed to adequately cover the costs of treating Medicaid patients. As a result, several hospitals intend to close or are considering closing affiliated doctors'

practices to new Medicaid patients while others are considering terminating their doctors' practices Medicaid contract with the state, the lawsuit said. (Boston Globe)

New York

- **Home Health Policy Shift Roils Albany**

  Gov. Andrew Cuomo's effort to overhaul New York state's $6 billion home health-care industry is coming under scrutiny from patient advocates and other industry players who say the administration is bowing to the interests of large, politically connected providers. Mr. Cuomo is pushing forward with his goal of enrolling tens of thousands of home-bound elderly, disabled and frail Medicaid patients into managed-care plans. It's a policy shift that has emerged as one of the most contentious issues in Albany. (Wall Street Journal)

Ohio

- **Ohio health care question cleared for fall ballot**

  Voters will get the chance to decide whether Ohio can opt out of the national health care overhaul after the state's top election official said Tuesday that opponents of the federal law have enough signatures to put a constitutional amendment on the Nov. 8 ballot. Secretary of State Jon Husted determined that supporters of the amendment, which would prohibit Ohio from participating in the federal Affordable Care Act, had gathered 427,000 valid signatures. They had submitted more than 546,000 and needed roughly 358,000 of them validated to make it on to the ballot. A liberal policy group, however, said it could file a challenge to the health care measure, because it was still finding invalid signatures in its review. (Associated Press)

Oregon

- **Oregon Insurance Division OKs 12.8 percent health insurance rate increase, rejects 22 percent**

  The Oregon Insurance Division will allow the state's largest health insurer to raise rates on individual premiums an average 12.8 percent, far lower than the 22.1 percent the company had requested. The division announced its decision Tuesday after a public hearing in June on the request by Regence BlueCross BlueShield of Oregon, the first such hearing in more than two decades. The reduced rate increase will affect about 59,000 residents who buy from Regence individually or for their families rather than through employers. (Oregon Live)

United States

- **Medicare, Medicaid Taken Off Table In Budget Talks**

  As of late Wednesday, July 27, 2011, neither the Boehner nor the Reid budget plans include cuts to Medicare or Medicaid. Kaiser Health News has discussion on why neither party is pushing for cuts to Medicare and Medicaid, and how cuts to either program could make it back on the table. (Kaiser Health News)

- **Federal Auditors Will Soon Review Health Insurance Rates in 10 States**

  The Obama administration will soon take over the review of health insurance rates in 10 states where it says state officials do not adequately regulate premiums for insurance sold to individuals or small businesses. At least one state, Iowa, has protested the federal decision and asked administration officials to reconsider. Several other states acknowledged that they lacked the power under state law to review health insurance rates. Several insurance commissioners tried and failed to get such authority from their state legislatures this year. Starting Sept. 1, federal and state officials will begin to scrutinize proposed rate increases of more than 10 percent to determine if they are justified. White House officials say their ability to publicize excessive, unreasonable rates will be a major protection for consumers under President Obama's health care law. (New York Times)

- **Medicaid cuts will challenge hospitals: Moody's**

  States will continue to look for savings in their Medicaid programs that will affect hospital reimbursements, and only good management, especially of expenses, can offset that trend, Moody's Investors Service said in a new report. Hospital and health system management teams will need to continue to cut costs, especially on labor and supplies and by delaying or scaling back capital projects, Moody's said. Unfunded pension liabilities and healthcare IT spending are both rapidly growing expenses that will be more difficult to curtail, according to Moody's. Management teams also can improve their organizations' ratings by demonstrating their abilities to execute reasonable strategic plans and quickly adapt to changing conditions, Moody's said. (Modern Healthcare)

PRIVATE COMPANY NEWS

- **Accelerated Rehabilitation Centers**, a Chicago-based outpatient physical therapy services company, has been sold by Gryphon Investors, a San Francisco-based private equity firm, to OMERS Private Equity. Terms of the deal were not disclosed. http://www.gryphon-inv.com/

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. Notable recent events include delays in the Washington and Massachusetts Behavioral RFP releases and the inclusion of New Hampshire's plan to implement Medicaid managed care.

Date	State	Event	Beneficiaries
July 30, 2011	Kentucky RBM	Contract awards	N/A
August 1, 2011	New Jersey LTC	Implementation	200,000
August 9, 2011	Massachusetts Behavioral	Proposals due	386,000
August 15, 2011	Kentucky RBM	Implementation	N/A
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
September 15, 2011	Washington	RFP Released	880,000
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 15, 2011	New Hampshire	RFI Released	N/A
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
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

HMA Recently Published Research

Health Reform: "DNA Profile"

National Update from Health Management Associates

Health care reform creates both opportunities and challenges for providers of all types: hospitals, FQHCs, physician groups and others. To take advantage of the opportunities and to mitigate the challenges, timely and accurate information on what health reform means to individual providers within their own service area is essential. Information on specific and potential policy changes and opportunities, community impacts and institutional financial performance must all be assembled, integrated and made practicable at the individual organizational level. HMA has developed a comprehensive, strategic summary for individual hospitals, hospital systems and state hospital associations called the Health Reform DNA Profile. There are two integrated parts, The Community Profile and the Financial DNA Profile. (Link to more)

Accountable Care in the Safety Net

National Update from Health Management Associates

Accountable care has emerged as a critical delivery system redesign companion to expanded coverage within federal health reform. Accountable care calls for providers to organize to provide a full continuum of services to patients and populations, to commit to improving quality while controlling cost, and to be rewarded as they succeed. However, the principles of accountable care are based upon CMS-supported demonstrations and lessons learned primarily in Medicare populations served by highly organized and integrated health systems. The "safety net" differs in the patient populations it serves, the structures and relationships between its providers, and its funding, which is mainly concentrated in Medicaid and local government reimbursement. Thus, the federal emphasis on the development of accountable care will need to be tailored for the safety net. CMS appears to understand this imperative and has created a "safety net unit" within the Center for Medicaid and Medicare Innovation, which is committed to seeding new approaches to integrated delivery and accountable care for current and future Medicaid populations. (Link to more)

California Exchange: "As Ambitious As You Can Be"

National Update from Health Management Associates

Led by its newly appointed Board, the California Health Benefit Exchange continues to make progress toward January 1, 2014 - the date by which millions of Californians will be seeking health coverage through its competitive marketplace. Since the first organizational meeting in April 2011, the Exchange Board has met several times and is steadily working on the critical items that must be in place before the organization can turn its attention to developing the coverage products that will be offered to Californians. Among the most pressing issues are the recruitment and retention of its first Executive Director and the preparation and submission of the Level 1 Establishment Grant to the federal government. (Link to more)

UPCOMING HMA APPEARANCES

Health Services Finance Officers (HFSO) Annual Meeting: "Development of Medical Homes with Integrated Services and Expanding Role of FQHCs"

Mark Trail, featured speaker

August 2, 2011

Charleston, West Virginia