HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 8, 2015

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THIS WEEK

IN FOCUS

NEW HAMPSHIRE RFA SOLICITS ADDITIONAL MCO(S)

This week, our *In Focus* section reviews the request for application (RFA) issued by the New Hampshire Department of Health and Human Services on April 1, 2015, which seeks to add at least one Medicaid managed care organization (MCO) to the state's two existing plans in the Medicaid Care Management (MCM) program. The MCM went live in December 2013 with three MCOs, but one has since withdrawn from the program. The MCM program currently serves more than 152,000 members as it prepares to add as many as 20,000 new members under Step 2 in MCM implementation later this year. Our In Focus this week reviews the background and current market of the New Hampshire MCM program as well as key elements of the RFA.

New Hampshire MCM RFA Overview

The RFA intends to award a contract to one or more MCOs that will join Well Sense and New Hampshire Healthy Families in serving the MCM program. This

is not a rebid of the existing contracts. Highlights and key elements of the RFA are detailed below.

Covered Population and Services

The MCM program covers nearly all service categories, with waiver services and nursing facility services to be phased in over the next year. This "Step 2" of the MCM program will also begin mandatory enrollment of currently excluded and opt-out individuals later in 2015, including dual eligibles and the foster care population.

DHHS indicates that for state fiscal year (SFY) 2015, there is an overall price limitation for all MCM contracts of $653 million, which is based on an estimated 1.415 million member months. This equates to average per-member-per-month (PMPM) capitation of roughly $461.50 for an average of 117,900 members. As a note, this does not include the implementation of Step 2 in SFY 2016. All told, there are close to 175,000 Medicaid members in New Hampshire, most of which will likely be in a MCM plan by 2016, at which point annual capitation payments to MCOs could exceed $1 billion.

Key RFA/Contractual Provisions for Bidders

- ***Payment Reform Plan.*** Current MCM contracts will begin seeing a one percent withhold of MCO capitation payments in each year of the Agreement under the Payment Reform Plan, which must be submitted for each contract year. The MCO will earn a pay-out of that withheld amount if it meets the implementation milestones described in the Payment Reform Plan. The pay-out will be pro-rated to the number of milestones achieved by the MCO at the end of the year.
- ***MLR, Risk Adjustment, Risk Corridors.*** Current MCM contracts target a medical loss ratio (MLR) of 89 percent, with a 9 percent administrative allowance, and 2 percent state premium tax. Capitation rates are risk adjusted for each MCO using the CDPS+Rx risk adjustment model. Additionally, risk corridors are in place to share gains and losses between the MCO and DHHS. Risk corridors are based on actual MLR as compared to target MLR, as follows:
  - Between 0 and 1 percent above/below: 100 percent MCO
  - Between 1 and 3 percent above/below: 50 percent MCO, 50 percent DHHS
  - Greater than 3 percent above/below: 10 percent MCO, 90 percent DHHS
- ***Auto-Assignment Algorithm.*** Current MCM contracts distribute auto-assignment of MCM members equally across each of the MCOs. However, the RFA does not indicate if there will be an open-enrollment with the award of additional MCO contracts or if auto-assignment would favor new entrants.
- ***HIPF and Hepatitis C Claims.*** MCM contracts indicate that the state will fully reimburse health plans for the Health Insurance Provider Fee (HIPF). Additionally, MCOs will be required to pay claims related to Hepatitis C medications on an administrative services only basis and will be reimbursed by DHHS in a retrospective manner. DHHS will

implement a pass-through program and develop pre-authorization guidelines related to Hepatitis C.

RFA Requirements and Scoring Criteria

The RFA requires responses to 15 technical questions, which fit into the evaluation criteria table below. Bidders are provided with the current MCM contract and framework for the implementation of Step 2 over the coming year.

Evaluation Criteria	Possible Pts.	% of Total
Experience (Q1, Q5, Q6)	60	18.2%
Capacity (Q2)	20	6.1%
Current Book of Work (Q3)	20	6.1%
Implementation Approach (Q4)	20	6.1%
Systems Architecture (Q7)	15	4.5%
Subcontracting Plan (Q8)	40	12.1%
Current Provider Network (Q9)	20	6.1%
Network Adequacy (Q10)	25	7.6%
Adequacy Timetable and Plan (Q11)	30	9.1%
Security/Risk Management Plan (Q12)	15	4.5%
Maturity Assessment (Q13)	20	6.1%
Data Retention (Q14)	15	4.5%
Continuity/Recovery Plan (Q15)	30	9.1%
Total Possible Points	**330**	

RFA Timeline

Per the RFA timeline below, interested bidders must submit a mandatory letter of intent (LOI) due by April 20, 2015. RFA responses are due to DHHS by June 1, 2015. The RFA does not indicate an anticipated contract award or implementation date at this time.

RFA Timeline	Date
Release RFA	April 1, 2015
Mandatory LOI Due	April 20, 2015
RFA Questions Due	April 29, 2015
Vendors Conference	May 7, 2015
Answers to Questions Posted	May 15, 2015
RFA Response Due	June 1, 2015

Contract Award and Term

As noted above, DHHS intends to award at least one MCM contract to join the existing plans serving the program. The initial term of the contract will be for two years, with an optional extension period of two additional years.

Background on New Hampshire MCM Program

New Hampshire launched the MCM program on December 1, 2013, after a delayed implementation process, which included the addition of a phased-in approach to mandatory enrollment for select populations, as well as long-term supports and services. Three MCOs were competitively procured to serve the MCM program:

- New Hampshire Healthy Families (Centene)
- Well Sense (owned by Boston Medical Center)

- Meridian Health Plan

However, on June 3, 2014, Meridian Health Plan announced it would withdraw from the MCM program in order to focus on its core business in the Midwest. By August 1, 2014, Meridian's 30,000 members had transitioned to the other two plans.

As of March 1, 2015, DHHS Commissioner Nicholas Toumpas reported there were 152,106 enrollees across the two remaining MCOs, with another 21,442 individuals outside the MCM program.

	MCM	NHHPP	Total Enrollment	% of Total
Well Sense (Boston Medical Center)	65,513	16,734	82,247	54.1%
New Hampshire Healthy Families (Centene)	55,273	14,586	69,859	45.9%
Total Enrollment	**120,786**	**31,320**	**152,106**	

Source: Commission on MCM Meeting Minutes, March 12, 2015.

NHHPP Transition to Marketplace

Enrollment figures in the table above include enrollees in the New Hampshire Health Protection Program (NHHPP), the state's Medicaid expansion vehicle. The NHHPP includes two programs. The Health Insurance Premium Payment (HIPP) program provides premium assistance to eligible individuals who have an offer of employer sponsored insurance (ESI), but cannot afford the monthly premium. The Bridge Program is for individuals who do not have an offer of ESI. The Bridge Program is a Medicaid Alternative Benefit Package program, which also provides non-emergency medical transportation and EPSDT benefits. Bridge Program enrollees currently select one of the two Medicaid MCOs, however CMS recently approved a one-year waiver that would convert it to a premium assistance program (PAP) for coverage through the Marketplace on January 1, 2016. There are currently around 38,000 Bridge Program enrollees who could be impacted by this change. DHHS has noted that if a MCM program enrollee is covered by a Medicaid MCO that also has a qualified health plan (QHP) on the Marketplace, they would be automatically enrolled into that plan. Further information on the PAP transition is available in the March 12, 2015 MCM commission meeting minutes, available here.

HMA MEDICAID ROUNDUP

Alaska

Legislature Debates Medicaid Expansion in Final Two Weeks of Session. On April 5, 2015, *TribTown.com* reported that the legislature will discuss Governor Bill Walker's Medicaid bill. However, House speaker Mike Chenault stated that the Medicaid system is broken and is seeking improvements before expansion happens. The Senate is also working on Medicaid legislation. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida LIP Negotiations on Hold, but CMS Pledges to Continue. On April 5, 2015, *Health News Florida* reported that discussions between Florida and CMS around the renewal of the Low Income Pool (LIP) program were on hold, but that CMS officials have pledged that negotiations are not off and that CMS has not stopped conversations with Florida on LIP. CMS issued a statement on the negotiations after it was reported that negotiations had halted. Read More

Governor Scott No Longer Supports Medicaid Expansion. On April 6, 2015, *Panama City News Herald* reported that Governor Rick Scott said he no longer supports Medicaid expansion. However, Scott is asking CMS to provide funding for Florida's Low Income Pool program. Read More

Expansion Cause of $4.2 Billion Budget Discrepancy between House and Senate. On April 2, 2015, *Tampa Bay Times* reported that the House approved a budget $76.2 billion budget, $4.2 billion less than the Senate-approved budget due to the House's refusal to expand Medicaid. Florida has rejected expansion for the last three years, affecting 800,000 uninsured. The Senate, however, hopes for a compromise and included expansion in its budget which was approved 36-0. The House stands firm in opposing it. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Emory University and WellStar Health System to Merge. On April 3, 2015, *Gwinnett Daily Post* reported that Emory University and WellStar Health System approved a resolution to begin the first phase of a merger. The deal will combine Emory's academic health system with WellStar's expertise in running community hospitals to form a new health care system. This will be Georgia's largest health system merger. Read More

Iowa

Governor Says He Has Broad Executive Authority on Institution Closings, Managed Care Expansion. On April 6, 2015, *WCFCourier.com* reported that Governor Branstad believes he has the authority as governor to close state institutions and transform Medicaid with no legislative input. Despite objections from lawmakers, he will begin closing mental health institutes. Read More

Louisiana

40,000 on Waiting List for Medicaid Home Care Services. On April 4, 2015, *The Washington Times* reported that Louisiana currently has 40,000 people on the state's waiting list for home care services funded by Medicaid, according to the state Department of Health and Hospitals. This number is expected to grow. The U.S. Census Bureau estimates that 25 percent of the state's population will be over the age of 60 by 2030, but because Medicaid funds are limited, nursing homes are near capacity. Statewide, nursing homes beds are 75 percent full. Statewide capacity was up only four percent in the last five years within the Louisiana Nursing Home Association. Read More

Missouri

Missouri Senate Approves Budget with Statewide Medicaid MCO Expansion. On April 8, 2015, the *Kansas City Star* reported that the Missouri Senate passed a budget bill during the night after a filibuster attempt to block its passage. A key factor in the budget that drew bipartisan opposition was a provision added by Senator Kurt Schaefer, chairman of the Senate appropriations committee, that would expand the state's regional Medicaid managed care program statewide. The move, if approved by the House and signed by Governor Jay Nixon, would shift around 200,000 beneficiaries from fee-for-service to managed care in the northern and southern regions of the state. The bill still excludes aged, blind, and disabled (ABD) populations from managed care. The House and Senate are now set to convene conference committees for budget reconciliation before the May 8, 2015 deadline to complete the budget. Read More

New Hampshire

Delayed Medicaid Billing System Up for Federal Certification. On April 4, 2015, *The Bellingham Herald* reported that New Hampshire's Medicaid billing system, initially approved in 2005, will finally be up for federal certification this month. The system was expected to be completed and online by the end of 2007. Delays prevented it from going online until 2013, when it became plagued by errors resulting in delayed payments to hospitals and doctors. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Division of Medical Assistance and Health Services (DMAHS) issues newsletter with Patient Pay Liability (PPL) and Provider-Collected Cost Share update. On March 24, 2015 DMAHS provided guidance to nursing facilities,

assisted living facilities and Medicaid managed care organizations about how to address overpayments made to providers by the Medicaid MCOs when the managed long term services and supports (MLTSS) program began in July 2014. In New Jersey, County Welfare Agencies (CWA) collect and calculate PPL information for long term care clients to offset the cost of care in an institutional setting. When MLTSS began there were delays in the processing of PPL which caused MCOs to inadvertently pay MLTSS claims from nursing and assisted living facilities without reducing payment by the PPL amount. The newsletter explains the process providers and MCOs will follow to reprocess previously paid claims and apply the appropriate PPL reduction. Read More

Court Rules State Can Deny Medicaid Benefits to Adult Non-Citizens in U.S. for Less Than Five Years. On April 2, 2015, *The Baltimore Sun* reported that the Supreme Court ruled that the New Jersey can deny Medicaid benefits to adult legal immigrants who have been in the United States for under five years. Read More

New Mexico

Preferred Care Partners Faces Lawsuit Against Inadequate Care. On April 2, 2015, *The Baltimore Sun* reported that a lawsuit will target several nursing homes run by Preferred Care Partners Management Group for inadequate care. According to the lawsuit a lack of nursing assistants is negatively impacting patients' access to needed services. Read More. On April 3, 2015, *The Charlotte Observer* reported that Preferred Care Partners issued a statement that it stands by the care it provides to residents. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Independent Health Reports Operating Loss. Independent Health, a health insurer operating a Medicaid managed care plan in Erie and Niagara counties, reported an operating loss of $75 million in 2014. The Buffalo News reports that after investments and taxes are factored in, the Amherst-based insurer reported a net loss of $60.2 million in 2014, one year after earning net income of $19.6 million, according to its annual filing with the state Department of Financial Services. Independent Health has over 380,000 members, of which 67,000 are enrolled in its Medicaid plan. Mark Johnson, Independent Health's executive vice president and chief financial officer, indicated that the company's commercial business and Medicaid business did as well, or better, than projected, and that the loss was driven by their Medicare business.

MVP Health Care Reports Operating Loss Despite Revenue Increase. MVP Health Care (MVP) reported a $12.4 million loss for 2014, significantly lower than its projected loss of $30 million. Its 2014 revenue was $2.9 billion, up from $2.5 billion in 2013, an increase of nearly 18 percent over the previous. A press release dated April 1, 2015, noted the plan's improved fiscal performance due to savings realized through the integration of Hudson Health Plan operations. MVP Health Care acquired Hudson Health Plan, a Medicaid managed care plan, in August 2013. MVP currently provides coverage to 25,000 Medicaid beneficiaries in 10 counties in the central and western part of the state; Hudson Health Plan has 147,000 members in five counties along the Hudson Valley.

Lutheran Medical Center to Become NYU Lutheran. It was announced this week that Lutheran Medical Center will become NYU Lutheran after receiving approval to join the NYU Langone Health System. Under the affiliation, NYU Lutheran will retain its own administrative and operational functions, as well as its own board of trustees.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Cleveland Clinic Sees 40 Percent Drop in Uncompensated Care After Expansion. On April 2, 2015, *Kaiser Health News* reported that charity care provided by the Cleveland Clinic dropped to $101 million in 2014 from $171 million in 2013. Hospital officials attribute the drop to Medicaid expansion and subsidies for low income patients. Read More

Budget Update. It's been nine weeks since the introduction of Governor John Kasich's 2016/2017 budget. Most recent Medicaid related testimony has centered on the Administration's controversial proposal to phase out Independent Providers of waiver services by 2019. Hearing testimony was followed by a clarification from the administration that Independent Providers working for individuals receiving waiver services through a self-directed waiver option, or working for an agency, will be permitted and that the self-direction option will be added to all of Ohio's HCBS waivers. But the budget bill itself, HB 64, is still waiting to be passed out of the House. The last public hearing was March 26th.

Law Passed in 2013 Saving Newborns. *The Dispatch* reported today that a law mandating the routine use of pulse-oximetry screening at birthing hospitals to screen for seven critical heart conditions is saving lives by detecting and treating congenital heart conditions. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's Department of Human Services issues Updated MCO Directory. Effective as of April 2015, the Office of Medical Assistance in Pennsylvania's Department of Human Services issued an updated contact list for managed care organizations participating in HealthChoices, the statewide mandatory Medicaid managed care (MCO) program. This list includes specifics related to service areas, individual names for primary contacts, phone, fax and email information for MCOs in Behavioral Health and Physical Health. The contractors for physical health include: Aetna Better Health, Gateway Health, United Health Care, UPMC for You, Health Partners Plans, AmeriHealth, Geisinger Family and Keystone First. For behavioral health the list includes Community Care Behavioral Health Organization (CCBHO), Community Behavioral Health, Magellan Behavioral Health, Value Behavioral Health and PerformCare. Read More

National

Feds Propose Rule to Protect Medicaid/CHIP Members under Mental health Parity Law. On April 7, 2015, *Kaiser Health News* reported that federal officials have proposed a rule to include Medicaid and CHIP members under the mental health parity law, which was passed in 2008 to ensure patients had mental health and addiction treatment benefits on par with medical and surgical care. The proposal would prevent managed care organizations from having hard limits on coverage such as a maximum number of mental health visits in a year and denied treatment would have to be explained by the insurer. The rule is expected to cost the state Medicaid program $150 million in additional behavioral health costs. Read More

Consumers Who Hover Near the Medicaid Lines Raise Concerns about Coverage and Marketplace Abilities to Handle Churning. On April 7, 2015, *Kaiser Health News* reported that individuals whose earnings fluctuate above and below the Medicaid line risk losing coverage. Some states are employing strategies to ensure people do not fall through the cracks. State exchanges can more easily integrate Medicaid and exchange plan data and information technology than federal exchanges. Read More

Industry News

Ventas to Acquire Ardent Health Services. On April 6, 2015, *Business Wire* reported that Ventas, Inc., a real estate investment trust, entered a definitive agreement to acquire Ardent Medical Services Inc. and its affiliates, which own and operate acute care health systems, for $1.75 billion in cash. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 8, 2015	Iowa	Proposals Due	550,000
May 14, 2015	Georgia	Proposals Due	1,300,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
California	39,731	42,473	44,804	48,976	51,527	58,945	122,908	123,079	124,239
Illinois	37,248	48,114	46,870	49,060	49,253	57,967	63,731	64,199	62,067
Massachusetts	18,836	18,067	17,739	17,465	18,104	17,918	17,867	17,763	17,797
New York							17	406	539
Ohio							68,262	66,892	65,657
South Carolina								83	1,205
Texas									20
Virginia	11,169	11,983	21,958	28,642	29,648	27,701	27,527	26,877	26,250
Total Duals Demo Enrollment	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**299,299**	**297,774**

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA News

Mike Nardone to Speak at Health Insights Spring 2015 Conference

April 8-10. Kiawah Island, South Carolina

HMA Principal Mike Nardone (Harrisburg, Pennsylvania) is a featured speaker at Health Insights' Spring 2015 Conference. The Spring 2015 Conference's educational focus is on "Medicaid – The Transformation of America's Largest Health Insurer" and will feature a panel presentation led by Dr. Bruce Vladeck, Sr. Advisor with Nexera/GNYHA Ventures and former Administrator of HCFA. In addition to Mike Nardone, additional featured speakers include Jesus Garza, CEO of Seton Healthcare Family and Arizona/Texas Ministry Market Leader for Ascension Health, and Cindy Mann, JD, former Deputy Administrator of the Center for Medicare & Medicaid Services and Director of Center for Medicaid, CHIP, and Survey and Certification. More Info

Chad Perman to Facilitate Session at National Partnership for the Health Care Safety Net: Cross-Community Summit

April 13. Washington, D.C.

HMA Consultant Chad Perman will facilitate a session titled "Considerations for Health Centers and Hospitals in Developing Successful Partnerships" at the National Partnership for the Health Care Safety Net: Cross-Community Summit. This session will explore important considerations for hospitals and health centers as they develop formal and informal partnerships. Speakers will discuss key principles for successful partnerships; legal considerations for formalizing partnerships; and considerations for health information technology, such as data sharing agreement, and electronic medical records.

Chris Armijo to Speak at Minority Health Community Forum

April 16. Denver, Colorado

HMA Community Strategies Senior Associate Chris Armijo will speak at the "Prevention is Power: Taking Action for Health Equity" community forum and discussion, hosted by the Colorado Office of Health Equity.

Dr. Jeffery Ring's Blog Post for Equity of Care Addresses Culturally Responsive Care

HMA Principal Dr. Jeffrey Ring's guest blog, "Culturally Responsive Care: Why and How" is currently featured on the website www.equityofcare.org.

Equity of Care is the national collaborative effort of the America's Essential Hospitals, American College of Healthcare Executives, the American Hospital Association, Association of American Medical Colleges and Catholic Health Association of the United States. Through this platform they have issued a call to action to eliminate health care disparities. Their goals are to increase the collection of race, ethnicity and language preference data; increase cultural competency training for clinicians and support staff; and increase diversity in governance and management. Through free resources, shared best practices and national collaborative efforts, Equity of Care hopes to lead the health field on a clear path to eliminate disparities and ensure that local action can affect national results.

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