

Proposal Narrative

Study 2: Insurance Markets

About Health Management Associates

Health Management Associates (HMA) is a consulting firm specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, data analysis, and health information technology and exchange. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Health Management Associates has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; New York City, New York; Atlanta, Georgia; Harrisburg, Pennsylvania; and Boston, Massachusetts.

HMA opened its New York office in 2007 and over the last four years has built its capacity to assist New York State and work with foundations and the major health care stakeholders in the state. Our staff provides a depth of experience and knowledge about all aspects of health care delivery and the health care policy environment of New York State. This local knowledge is cross-fertilized by the breadth of our experience working in states across the country.

HMA's clients include the major safety net health systems, private sector providers, and local, state, and federal governments. The firm has extensive experience and expertise in the design and implementation of health programs, particularly with respect to system development, managed care, long-term care, and behavioral health care.

The staff of HMA is composed of over 90 professional health care managers and analysts with up to thirty years of experience in the health and human services fields, including senior staff with long experience in clinical and administrative leadership of public hospitals. HMA brings a strong

interdisciplinary expertise to clients. Staff backgrounds include health economics, public health policy and administration, health care finance and reimbursement, clinical services, managed care, pharmacy benefit design and management, social work, program development and evaluation, and information systems.

Health Management Associates (HMA) is pleased to present this proposal to provide health benefit exchange implementation planning support to New York. As a national health care consulting firm widely regarded as a health care policy thought leader, HMA is uniquely positioned to perform the work necessary to support this project and will offer the New York State Department of Health access to national expertise in health reform and insurance exchange planning and implementation that includes a team of seasoned professionals with:

- Hands-on experience in the design, development and operation of one of the first health insurance exchanges in the nation, the Health Insurance Connector in Massachusetts;
- A former state insurance official responsible for Health Insurance Reform and Exchange planning in Texas;
- Involvement in negotiating and designing the first health insurance exchange under the Affordable Care Act;
- Extensive experience working with the states of Michigan, Illinois, Connecticut, Nebraska, and Tennessee to plan for their Exchanges;
- Leading health economists and financial modelers, including a distinguished University of Maryland professor;
- Expertise in the New York health policy arena and relationships with key stake holders and policy makers.

The HMA team has extensive experience in developing and implementing state-based health reform projects and understands the complex challenges of creating a Health Insurance Exchange. Our

experience enables us to quickly and efficiently assess and describe options, identify key questions, access available knowledge sources, and customize solutions to meet New York's needs. This study will discuss the advantages and disadvantages for requiring plans to sell all product levels in the Exchange and whether to make the Exchange the entire market for health insurance. It will explore the key issues in the relationship between the Exchange and the external insurance market for both the individual direct pay market and for the small group market.

The study will include an assessment of various decision points and the short and long term impact on the existing market place. HMA is confident that our staff's previous experience working with Massachusetts and California to study and analyze similar decisions, along with state-specific expertise from our New York-based HMA staff, make us uniquely positioned to help New York design an exchange that avoids adverse selection and maximizes consistency between the Exchange market and the outside markets.

Throughout this project, the HMA team understands that federal guidance and requirements will be an evolving but essential area to monitor closely. Our team is involved in Exchange planning efforts in multiple states and with federal regulators, and we are confident that we will be able to provide the most up-to-date and relevant information to guide the overall effort of this project. We will continually monitor the information released by the CMS Center for Consumer Information and Insurance Oversight (CCIIO), the National Association of Insurance Commissioners, and planning materials and documents published by other states as they conduct similar analyses. Throughout the study time period, the HMA team will continually review ACA requirements and any new guidance/regulations issued by HHS to identify ways in which New York can meet important Exchange goals, consistent with ACA requirements, including:

- Promoting efficiency
- Avoidance of adverse selection

- Streamline access and continuity of care
- Engagement of stakeholders and consumers in planning an implementation
- Public accountability and transparency
- Financial accountability and stability.

To ensure our work is accomplished within the limited time frame, HMA will use a project tracking and management system that involves weekly reporting by project staff, bi-weekly meetings (at a minimum) with all team members, regular progress assessments that track completion stages with the project timeline, and a continuing assessment of the project Scope of Work to ensure the deliverable meets all requirements. Adjustments in staffing assignments will be made if necessary to accommodate the compressed work schedule, or if our work results in identification of additional evaluation that would require the unique skills of other HMA staff members. HMA will confirm with the New York State Department of Health before adding any additional staff to the project. HMA will provide project updates on a regular basis and will be available for conferencing and/or travel to New York in conformance with the agreed-to project budget.

Proposed Study Method

A thorough understanding of the current health insurance market is a critical component to effective Exchange planning. The Affordable Care Act will change the landscape of the marketplace by changing incentives for insurers, employers and consumers. While the small group and individual direct pay markets will be completely restructured under rating reform and the operations of the Exchange, changes to employer incentives will likely also lead to changes in the large group and self-insured segments of the market. The information compiled and distilled in this study will provide an overview of the current landscape, as well as important data that can be used to model implications of certain key policy decisions.

In order to develop a comprehensive snapshot of the current marketplace, the HMA team will work with State staff to identify, collect and process existing data on the health insurance market structure, including the Healthy New York program and early information from the NY Bridge Plan. To the extent that small group data are available from rate filings, we will gather and summarize those details. We will leverage these existing data sources to the extent possible. Research presented by the United Hospital Fund, especially in its yearly reports on enrollment and finances for New York’s insurance markets,¹ will provide essential background information.

HMA will review existing data with staff from the Department of Financial Services and the Department of Health to determine whether current information will be able to provide the level of detail and insight required for this task, especially for the individual and self-insured market segments. If it is determined that existing data are insufficient, we would propose to work with some of the key insurers offering products in the New York marketplace. The table below shows the types of information and stratification that we will request from significantly sized insurers in New York.

Market Characteristics	Carrier Characteristics	Product Characteristics	Data Elements
<ul style="list-style-type: none"> Insurance Market Segment Geographic Region 	<ul style="list-style-type: none"> Type of products offered (Comprehensive or Limited Benefit) 	<ul style="list-style-type: none"> Actuarial Value Deductible Level Benefit Designs and Descriptions 	<ul style="list-style-type: none"> Enrollee Distributions by Rating Tier Policies Members Premiums Claims Group size (where applicable) Broker Compensation Level and Structure

With the data collected as described above, we will have the ability to compare per capita premium and claim costs at different benefit levels for each region in the state. This information

¹ Peter Newell & Allan Baumgarten, *The Big Picture III: Private and Public Health Insurance Markets in New York*, 2009. United Hospital Fund, 2011; Peter Newell, Allan Baumgarten, & Jenny Heffernan, *The Big Picture Updated: Current Status of New York’s Health Insurance Markets*. United Hospital Fund, 2010.

provides valuable insight into consumers' purchasing decisions, as well as current market relative risk distribution. These data will also form baseline information for modeling the effects of reform changes to the market as described later.

DATA AND METHODS

To gain a more complete picture of the current New York market, the HMA team will synthesize the information received from insurers and TPAs with other sources of useful market detail, such as Mercer's National Survey of Employer-Sponsored Health Plans. Sources such as the U.S. Census Bureau's Current Population Survey (CPS) and the Agency for Health Care Research and Quality's Medical Expenditure Survey (MEPS) will provide insight into how wages and income levels associate with various types of coverage in New York. This data set includes detailed information that may be used in assessing the rate at which employers of various sizes offer health insurance coverage to their employees and the rate at which employees choose to enroll in the available coverage. Additional MEPS data on the level of cost-sharing requirements (deductibles, coinsurance, copays, and limits on specific services) will also assist in our evaluation of affordability as it relates to the underinsured population. HMA will also contact various academic, research and policy groups to identify any additional information that is available.

HMA will research other state exchanges to determine what their actions have been to date to try and monitor/deter adverse selection between the internal and external markets to the Exchange as well as within the benefit structure. HMA would also research the voluntary purchasing pools and exchanges that were established prior to the passage of the Affordable Care Act.

Our analysis will include, but is not limited to, the following activities:

- Our team will consider the State's goals and federal requirements with respect to the Exchange, along with issues relating to efficient delivery of services to the target markets and economies of scale associated with administering the Exchange. There are a number of state policy decisions

that will influence the likely size and composition of the Exchange market. Examples of the types of decisions that will impact the Exchange market include regulation of the non-Exchange individual and small group markets beyond what is required by the ACA and whether the state extends the definition of “small group” to employers with fewer than 100 employees.

- Exchange administration cost levels may vary based on a number of factors, including but not limited to the size of the market to be served through this purchasing mechanism. The extent to which the state is able to leverage or build on existing infrastructure rather than building new systems will influence the costs, as will state decisions about whether to use the Exchange to promote state healthcare goals, such as alternative delivery or reimbursement systems or higher quality standards.
- The majority of health plans serving Medicaid beneficiaries do not typically have a commercial market presence as well. This is especially true in New York given the significant role of the PHSPs (New York’s Public Health Plans), who currently serve over 70 percent of the Medicaid managed care market, and have no commercial products. The extent to which plans will or should be encouraged to participate in both Medicaid and the Exchange is essential to understanding how the markets relate to one another. It also raises important questions. For example, should the state consider operational and policy approaches that encourage individuals to remain in the same plan when transitions occur between the Exchange and Medicaid? And should the state favor a fully competitive environment in the Exchange? The HMA team’s analyses will help the state define these issues and balance potentially competing goals in a way that serves consumers and the strategic goals of the Exchange while treating participating plans fairly.

Other design features that will be included in the study include:

- Whether the state limits the market to only those plans offered through the Exchange, or whether alternatives should continue to be available to consumers outside the Exchange and what factors to consider under both scenarios;
- Operational and fiscal consequences of various design decisions.

Under ideal conditions, the Exchange will provide individuals and small businesses with the knowledge to make informed decisions about their health care coverage and will encourage competition between health plans to allow for more affordable health care coverage for all New York residents. The Exchange will be at the center of transforming New York's health insurance landscape, making it easier for individuals and small businesses to purchase health insurance and increasing the availability of coverage for those who are currently uninsured. However, the success of the Exchange depends largely on a thorough understanding of the New York insurance market, the interaction between Medicaid and the commercial insurance market, and a decision process that carefully considers the impact of specific design features. Determining how best to position the Exchange so that it complements and supports the state's commercial health insurance markets, Medicaid and subsidized programs will require an unprecedented amount of collaboration between the state and federal government, across state agencies, among stakeholders and throughout the New York health insurance industry. This level of collaboration begins with a common understanding of the approach and objectives of the ACA. HMA's research and analysis and development of Exchange design options will incorporate the many technical requirements of the ACA to ensure the state is well positioned to make implementation decisions and has the information necessary to apply for federal funding. Our report will clearly lay out each step of the design and implementation planning process in a way that is both practical and achievable for the state.

Staff Qualifications

Staff	Hours
Denise Soffel	65
Jennifer Kent	40
Jack Meyer	50
Caroline Davis	45
Dianne Longley	45
Tom Dehner	20

Denise Soffel, PhD, is a principal at HMA in the New York office, and will serve as Project Manager for this study. She joined HMA in 2011, bringing over 25 years of experience in health policy analysis and advocacy. Prior to joining HMA Dr. Soffel worked for the New York State Senate as Executive Director to the Committee on Health. In that capacity she served as the lead policy advisor to the committee, developing budgetary and legislative priorities. She also coordinated efforts between the executive and legislative branches, and worked closely with the executive branch on federal health reform implementation in New York. Prior to her work in the NYS Senate, Dr. Soffel worked at the National Center for Law and Economic Justice and at the Community Service Society of New York, developing and implementing policy, advocacy strategy and programs to improve and strengthen publicly financed health programs. Dr. Soffel started her career in the Peace Corps as a health extension agent in Paraguay, South America. Dr. Soffel earned her Bachelor of Arts at Clark University, and her Masters and PhD in Public Administration at New York University’s Wagner Graduate School of Public Service. She also was a Postdoctoral Fellow in the Pew Health Policy Program at the Institute for Health Policy Studies at the University of California, San Francisco.

Jennifer Kent is a principal in HMA’s Sacramento office. Jennifer has served in California state government for nearly seven years, and comes to HMA from California’s Department of Health Care Services where she has most recently served as the Associate Director responsible for implementing state and national health reform initiatives for Medi-Cal. Jennifer has also coordinated stakeholder

involvement, and issues of other affected state departments, in the implementation of California's comprehensive 1115 waiver, and provided policy and strategic advice on fiscal and budgetary matters. Prior to this assignment, Jennifer served as the Deputy Legislative Secretary in the Office of the Governor. In this post, Jennifer was Governor Schwarzenegger's lead policy and strategic advisor on California's Health Exchange legislation, and served as the legislative lead for all matters pertaining to health, human services, managed care, revenue and taxation, health-related boards, veteran affairs, and alcohol regulation. Jennifer also worked extensively on the state budget issues and negotiations involving the health and human services assignment. Before joining the Office of the Governor, Jennifer served in both the California Health and Human Services Agency and the California Department of Health Services. Jennifer earned her Bachelor of Arts degree at Saint Mary's College of California and her Master's in Public Administration degree at the University of Southern California.

Jack A. Meyer, PhD, is a managing principal in HMA's Washington, DC office. In this capacity, Dr. Meyer is conducting health care research, policy analysis, and strategic planning for grant-making foundations, health industry leaders, and state and federal agencies. Dr. Meyer is also a Professor in the School of Public Policy and the School of Public Health at the University of Maryland.

General areas of recent and current work include:

- Help states and the federal government build Health Insurance Exchanges
- Conduct research to determine the complex medical needs of lower-income populations and design care management programs to meet these needs
- Analysis of the ingredients of hospital quality and patient safety
- Review of promising models of health care delivery system reform at the local level

Dr. Meyer's recent publications include "Making the Investments Work: Important Benefits and Key Challenges in Implementing Health Reform in Florida." Collins Center for Public Policy. February 2011; "County and City Health Departments: The Need for Sustainable Funding and the Potential Effects

of Health Care Reform on Their Operations, September 2009” “Chronic Disease Management: Evidence of Predictable Savings.” Health Management Associates. November 2008; “*Mapping Health Spending and Insurance Coverage in Ohio*,” prepared for the Health Policy Institute of Ohio, *Mapping Health Spending and Insurance Coverage in Connecticut*,” prepared for the Universal Health Care Foundation of Connecticut; *Hospital Quality: Ingredients for Success*, prepared under a grant from the Commonwealth Fund; “Building on the Job-Based Health Care System: What Would It Take?” *Health Affairs*; and *Covering America: Real Remedies for the Uninsured*, prepared under a grant from the Robert Wood Johnson Foundation.

Caroline Davis, Senior Consultant, has extensive experience in health financing, policy development and implementation at the Federal, State and local levels, with an emphasis on Medicare, Medicaid, and CHIP. Prior to joining HMA, Ms. Davis was a founding member and Senior Operations Manager for the California-based Center to Promote HealthCare Access (now known as Social Interest Solutions) and a Program Officer with the California HealthCare Foundation’s Health Information Technology program area. In both roles, she focused on the use of technology to improve the eligibility and enrollment processes for public sector health programs. She also has served on the senior staff of California’s Medicaid (Medi-Cal) program, where she worked on a variety of policy, financing, reimbursement and operational issues in both fee-for-service and managed care programs. In addition, Ms. Davis was the lead Medicare analyst at the White House Office of Management and Budget (OMB). In this capacity, she directed staff in budget analysis and policy development, and she advised senior White House and OMB officials on Medicare provider payment issues and Medicare reform options.

Ms. Davis holds a Bachelor of Arts in political science from Carleton College and a master’s degree in public policy from Duke University.

Dianne Longley is a principal in HMA’s Austin office. Prior to joining HMA, Ms. Longley was Director of Health Insurance Initiatives for the Life, Health and Licensing Division at the Texas

Department of Insurance. Her primary responsibilities included directing research, data collection and analysis related to health insurance, health technology and health care issues, and providing technical assistance to various legislative committees. She also had responsibility for directing implementation of federal health insurance reform and oversaw Department activities related to implementation of several legislative initiatives designed to improve health care transparency as it relates to reimbursement and health insurer payment issues. From 2001 through 2006, she served as Director of the Texas State Planning Grant Program, a comprehensive five-year study of the uninsured, and continues to coordinate the Department's efforts to expand health insurance coverage in Texas, including implementation of the recently enacted Healthy Texas Program for small employers. Her professional appointments include the National Workgroup for Electronic Data Interchange (WEDI) Board of Directors, Governor's Health Care Policy Council, East Texas Rural Healthcare Access Program, National Uniform Claim Committee, Texas Health Care Information Council, and the Texas Hospital Data Advisory Committee. She holds a Bachelor of Science Degree from Texas A&M University.

Organization Experience

HMA is currently working or has worked in six states on activities related to the planning, design and implementation of Health Insurance Exchanges. We anticipate continuing work with these six states and others as they seek additional federal funding and begin to implement Exchanges.

MICHIGAN - EXCHANGE PLANNING

HMA is currently serving as the prime vendor for Health Insurance Exchange planning services for the State of Michigan. HMA and its partners managed a comprehensive stakeholder facilitation process, completed research tasks related to Health Insurance Exchange planning and presented the

state with a comprehensive work plan for Health Insurance Exchange implementation. Major project tasks have included:

- Operating five stakeholder work groups to address Exchange governance, business operations, evaluation and reporting, technology, and regulations.
- Research on persons potentially eligible for coverage through the Exchange and how the Exchange will impact Medicaid, other public programs, and other state health plans.
- Quantifying resources, staffing needs and capabilities to support the implementation and functions of the Exchange.
- Exploring how the Exchange will manage reporting, accounting, and auditing functions while maintaining transparency.
- Reviewing technical components and interoperability of technology embedded in existing state systems and planning for the introduction of possible new systems necessary to properly run an Exchange and other public programs, including Medicaid.
- Review of necessary state statutory and regulatory changes needed to establish the Exchange options.
- Recommendations on all of the above.
- Timeline and work plan for Michigan's next steps.

ILLINOIS - EXCHANGE PLANNING AND ENROLLMENT/VERIFICATION/ELIGIBILITY SYSTEM DESIGN

HMA was awarded a contract to complete a needs assessment to support Illinois Health Insurance Exchange planning activity and to develop an enrollment, verification, and eligibility system for individuals seeking Exchange-based and Medicaid health coverage. The HMA team was tasked with:

- Projecting likely costs associated with implementing an Exchange in Illinois, with specific focus upon new staff, infrastructure, information technology and outreach costs.
- Developing a comprehensive summary of necessary changes in state insurance regulation associated with new requirements established by the ACA and creation of a state Health Insurance Exchange.
- Identifying a source for long-term financing for Illinois' Health Insurance Exchange.
- Completing an analysis of the likely impact Illinois' Health Insurance Exchange would have upon other state programs.
- Providing a review of the current processes and information technology tools utilized for eligibility determination of public assistance programs like Medicaid, Supplemental Nutrition Assistance Program (SNAP) and cash assistance through Temporary Assistance for Needy Families (TANF).
- Determining Federal requirements for eligibility, verification, and enrollment (EVE) through an Exchange and identifying possible resources available to support implementation of necessary EVE changes.
- Identifying options available to the state for the effective implementation of necessary changes in EVE functions to support Health Insurance Exchange operations.
- Developing a plan and budget for eligibility, verification and enrollment implementation once Illinois has identified a preferred strategy.

NEBRASKA - EXCHANGE PLANNING

HMA and its partners have been providing research on the current status of health insurance coverage in Nebraska and assisting the state in identifying the structural and fiscal impact of Health Insurance Exchange planning. HMA and its partners have been tasked with:

- Completing an analysis of the insurance market in Nebraska including a demographic breakdown of those who are currently identified as insured, uninsured and underinsured.
- Assessing health insurance affordability in Nebraska with specific focus upon average premium and other out-of-pocket costs imposed on individuals currently accessing health coverage.
- Providing a descriptive analysis of the Nebraska insurance market, with data outlining the number of products within each market, the number of policy holders accessing each product and common benefit and cost sharing designs identified in Nebraska.
- Projecting the financial impact of implementing a Health Insurance Exchange in Nebraska; including an estimate of an Exchange's impact upon individual and group insurance rates, necessary broker fees, and insurance carrier fees for Exchange participation.
- Developing economic models detailing the likely impact of a Health Insurance Exchange being run by an existing state agency, a newly created state entity, a regional entity or by the Federal government. The analysis includes the likely impact of underwriting requirements, premium cost, caseload, and other structural elements of a Health Insurance Exchange.

CONNECTICUT - EXCHANGE PLANNING

As a subcontractor to Mercer, HMA's scope of work includes:

- Completing an assessment of the uninsured and underinsured in Connecticut under various types of public and private health insurance coverage.
- Assessing the impact of the Health Insurance Exchange upon the Medicaid program, with specific information about the impact on eligible adults, eligible children, and eligibility groups by income.
- Developing a financial model for a sustainable Exchange.

- Analyzing Exchange implementation options, including state or federal Exchange, statewide or regional Exchanges, separate or combined Exchanges, and governance models.

TENNESSEE - EXCHANGE PLANNING

In Tennessee, HMA is one of four firms being utilized by the Department of Finance and Administration to support different aspects of the planning and design of its Exchange. HMA is currently working with (or has worked with) the state on:

- Developing both of the state's Level 1 Grant Applications (one submitted September 30, 2011; one planned for December 30, 2011); and
- Drafting an extensive policy document that examines the various policy options available to the state versus a federally-run Exchange.

PUERTO RICO - EXCHANGE PLANNING

HMA has recently begun work in Puerto Rico on its Exchange planning and development with actuarial partner Milliman. The scope of work in Puerto Rico includes:

- Performing a study to identify the provisions of the ACA that apply to Puerto Rico's unique status and developing a roadmap to identify all the options that the territory will need to make in creating an Exchange;
- Conducting a high-level market analysis of the impact of the ACA on the insurance market;
- Developing financial sustainability and budget models for an Exchange;
- Conducting an extensive study of the uninsured and underinsured in Puerto Rico;
- Offering actuarial support to the financial and market impacts, including data on the premium levels, retention and loss ratios for both baseline and multi-year trends;

- Modeling various Exchange options including adverse selection impacts of various policy decisions, the Basic Health Plan option and the merging of the individual and small-group markets;
- Initiating and conducting a formal stakeholder process;
- Studying the current insurance market in Puerto Rico and surveying the territory’s insurance agent and broker community for input on the market impacts of the ACA;
- Assessing current health programs and developing integration options; and
- Conducting a formal analysis on “churning” and developing options for Puerto Rico to consider in lessening or reducing this activity in the market and the Exchange itself.

Timeline

The table below includes an overview of the project work plan, deliverables and due dates for each piece.

Project Deliverables and Work Plan	Due Date
<u>Deliverable: Preliminary Analysis and Progress Report</u> <ul style="list-style-type: none"> • Overview of survey activity, research analysis and data sources; discussion of preliminary findings; review of initial Exchange planning activities; identification of questions or issues requiring guidance from DOH 	Feb 17, 2012
<u>Deliverable: Draft of Discussion and Recommendations on Insurance Market Participation</u> <ul style="list-style-type: none"> • Study of New York health insurance marketplace; review of plan designs, standardized benefits programs, and payment models; analysis of adverse selection risks • Assessment of existing market; evaluation of maintaining mandated benefits not included in essential medical benefits and how it relates to minimizing adverse selection 	March 16, 2012
<u>Deliverable: Final Study on Insurance Markets, including Discussion on Exchange Design Options, Organizational and Impact Assessment Report</u> <ul style="list-style-type: none"> • Evaluation of Impact on Existing Marketplace; includes list of major policy decisions New York must address in establishing the Exchange and analysis of placing the entire market in the Exchange; how risk selection can be minimized through market rules and how the definition of small employer should be considered and its impact to the SHOP. 	March 30, 2012

Proposed Report Outline

HMA proposes the following outline/table of contents for the final report:

Overview of survey activity, research analysis and data sources

New York Health Insurance Marketplace

- Review of plan designs, standardized benefits programs, and payment models
- Analysis of adverse selection risks

Assessment of Existing Market

- Evaluation of maintaining mandated benefits not included in essential medical benefits and how it relates to minimizing adverse selection

Exchange Design Options, Organizational and Impact Assessment

- Evaluation of impact on existing marketplace
- Analysis of placing the entire market in the Exchange
- How risk selection can be minimized through market rules and
- How the definition of small employer should be considered
- Impact to the SHOP

Policy Options and Recommendations

Subcontractor Role

HMA does not propose to use any subcontractors for this study.