

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... July 10, 2019



[RFP CALENDAR](#)

[HMA News](#)

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IN FOCUS

CALIFORNIA 2019-20 BUDGET OVERVIEW

This week, our *In Focus* section reviews the California fiscal 2019-20 budget. California Governor Gavin Newsom signed his first budget, and much of its related legislation on June 27, 2019. The budget appropriates \$214.8 billion (\$147.8 billion General Fund) in total spending with \$19.2 billion in reserves. The total reserves includes \$16.5 billion in the Rainy Day Fund, \$1.4 billion in the Special Fund for Economic Uncertainties, \$900 million in the Safety Net Reserve, and nearly \$400 million in the Public School System Stabilization Account.

Total Health and Human Services (HHS) funding increased from \$160 billion (\$39 billion General Fund) in 2018-2019 to \$162.3 billionⁱ (\$41.4 billion General Fund) in 2019-20, an increase of \$2.3 billion (1.4 percent). The total HHS funding includes \$102.2 billion (\$20.3 billion General Fund) for the Department of Health Care Services (DHCS), California's Medicaid agency.

Medi-Cal (California's Medicaid program) related items in the budget include:

Expanding Medi-Cal coverage to undocumented individuals between 19 and 25 years of age. \$98 million (\$74.3 million General Fund) is included in the budget for this coverage expansion. This expansion builds on the existing undocumented coverage through 18 years of age, but doesn't extend as far as the Senate proposal, which would have also provided coverage for undocumented individuals 65 years of age and older.

Expanding Medi-Cal coverage to low-income seniors (65 and older). \$124.9 million (\$64 million General Fund) is included in the budget for this coverage expansion. The ACA includes Medicaid expansion of up to 138 percent of the federal poverty line (FPL) for individuals between 19 and 64, but not for individuals 65 and older. With this Medi-Cal expansion to low-income seniors, now low-income individuals 65 and older are eligible for the same coverage as low-income adults 19-64 up to 138 percent FPL.

Managed Care Organization (MCO) tax. The current MCO tax runs through June 30, 2019, and the Administration was not seeking a renewal of the tax. The Legislature wanted a renewal of the tax to draw down federal matching funds, and the budget authorizes the State to seek renewal of the tax with the federal government. Federal approval is required for renewal of the tax.

Restoring Medi-Cal optional benefits. In 2009, the State eliminated the Medi-Cal optional benefits (which include optical, audiology, and others) due to the Great Recession. The budget restores these benefits for three years.

Tobacco tax revenue allocation (Proposition 56). The budget includes: \$2.7 billion for supplemental provider payments to physicians, dentists, and other Medi-Cal providers; \$544.2 million to establish a value based payment program; \$120 million in one-time funding for the Physicians and Dentists Loan Repayment Program; \$105 million for developmental and trauma screenings; and \$50 million for provider training to deliver trauma screenings.

Prescription drug carve-out. In January, Governor Newsom issued an executive order directing DHCS to move the Medi-Cal managed care

ⁱ The HHS and DHCS totals are from the May Revision; the final totals will be posted in the coming weeks under the "Enacted Budget" section of the following website: <http://ebudget.ca.gov/home.php?selectedYear=2019-20>

pharmacy benefit to fee-for-service (FFS) by 2021. The budget directs DHCS to establish a pharmacy advisory group, which it will keep updated on changes and savings expected from the carve-out, to interact with stakeholders.

In-Home Supportive Services (IHSS). The budget restores the 7 percent reduction in IHSS hours through December 31, 2021.

Additional \$120 million in funding for the Whole Person Care Program. The budget makes available an additional \$100 million through June 30, 2025 for the Whole Person Care Program, or a successor program, to provide supportive housing services, including, but not limited to, rental subsidies. Funding will be prioritized for individuals with mental illness who are also homeless or are at risk of becoming homeless. The budget also makes an additional \$20 million available for non-Whole Person Care counties (through June 30, 2025) for development and implementation of programs to focus on coordinating health, behavioral health with a mental health or substance use disorder, and critical social services such as housing.

Health Home Program timeline extension. Existing law authorizes DHCS, subject to federal approval, to create the Health Home Program for enrollees with chronic conditions. Existing law also creates the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds for the purposes of implementing the program. This budget extends the availability of the funds for implementing the program from June 30, 2020 to June 30, 2024.

Healthcare related items beyond Medi-Cal include:

Additional healthcare items in the budget include a **state individual mandate** coupled with **additional assistance for purchasing insurance on Covered California, the State's ACA Exchange**. The budget includes a requirement for all Californians to have health insurance or pay a penalty. The individual mandate was previously required by the federal government, but it was recently zeroed out by Congress. The money received from the state individual mandate is expected to bring in approximately \$1 billion for premium assistance for the next three years. There is also an additional \$450 million in the budget to supplement this \$1 billion over the next three years.

The premium assistance is for individuals between 200 and 600 percent of the FPL. Individuals between 200 and 400 percent of the FPL will receive additional assistance while individuals between 400 and 600 percent will receive assistance for the first time to buy insurance on Covered California. The 2019-20 Budget includes \$428.6 million for premium assistance with 17 percent of the amount allocated for individuals between 200 and 400 percent of the FPL and 83 percent allocated to individuals between 400 and 600 percent of the FPL.

For more information, please contact [Jason Silva](#).



HMA MEDICAID ROUNDUP

Alaska

Governor Vetoes \$50 Million in Medicaid Funds From State Budget. *KTUU* reported on June 28, 2019, that Alaska Governor Mike Dunleavy has vetoed \$50 million in Medicaid funds from the state's fiscal 2020 budget. Dunleavy said that some Medicaid cuts, including adult dental, will be covered by a full statutory Permanent Fund dividend. In total, Dunleavy vetoed \$444 million from the 2020 budget. [Read More](#)

Arizona

Centene Subsidiary Takes Over Health Care Services in Prisons. *ABC 15 Arizona* reported on July 1, 2019, that Centurion, a Centene subsidiary, is taking over the contract to provide health care services in 10 Arizona state-run prisons. Corizon had previously held the contract. The Arizona Department of Corrections has faced a class action lawsuit, which claims that poor prison medical services led to inmates' deaths and preventable injuries. [Read More](#)

Arizona Releases Medicaid Statistical Snapshot. The Arizona Health Care Cost Containment System (AHCCCS) released a Medicaid statistical snapshot, including data on enrollment, costs, claims, and utilization. Total Medicaid enrollment in Arizona was 1.8 million in April 2019, with 98 percent enrolled in a managed care plan. Long term services and supports enrollment was 64,179. Per member per month costs in fiscal 2017 were \$6,100. [Read More](#)

California

Exchange Premiums to Rise 0.8 Percent in 2020, Lowest Since 2014. *Kaiser Health News* reported on July 9, 2019, that insurance premiums on the Covered California Exchange will rise 0.8 percent in 2020, the lowest rate of increase since the program was launched in 2014. Washington and Maryland also announced low premium increases of 1 percent and 2.9 percent, respectively. [Read More](#)

Governor Signs Bill to Offer Medicaid to Illegal Immigrants, Ages 19 to 25. *U.S. News* reported on July 9, 2019, that California Governor Gavin Newsom signed into law a bill that offers Medicaid benefits to illegal immigrants age 19 to 25. State officials predict 90,000 people will receive coverage at a cost to the state of nearly \$100 million. The state already covers undocumented children 18 or younger. [Read More](#)

California to Pay Off \$58.6 Million in Medical School Student Loans for 247 Physicians Serving Medi-Cal Patients. On July 1, 2019, the California Department of Health Care Services announced that it will pay off \$58.6 million in medical student debt for 247 physicians who commit to serve Medicaid patients. Nearly 1,300 physicians applied for the CalHealthCare loan repayment program, which is intended to incentivize doctors to serve Medi-Cal members. The state will announce awards for dental applicants later this summer. This is the first of five rounds of funding.

Florida

Medicaid Expansion Could Lead to State Savings, Report Says. *WUSF News* reported on July 8, 2019, that Florida could save \$200 million for fiscal 2023 by expanding Medicaid, according to a report by the Florida Policy Institute. The savings could come as federal dollars potentially replace millions of state dollars spent on programs for mental health and substance abuse, hospital inpatient care for prisoners, and uncompensated care. [Read More](#)

Illinois

Illinois Fills Job Vacancies to Reduce Delays in Medicaid Application, Renewal Process. *Crain's Chicago Business* reported on July 1, 2019, that Illinois has embarked on an "aggressive cross-agency effort" to reduce delays in the processing of Medicaid applications and renewals, including the filling of hundreds of job vacancies. The effort, led by the Department of Healthcare and Family Services and the Department of Human Services, also includes updating policies, creating progress reports, and more. [Read More](#)

Illinois Owes \$4.1 Million in Medicaid Funds, Federal Audit Says. *The Chicago Tribune* reported on June 28, 2019, that Illinois owes the federal government \$4.1 million because the state failed to seek certain drug rebates, according to an audit. The government is recommending Illinois repay the \$4.1 million and improve its Medicaid billing processes. [Read More](#)

County Officials Question Why Medicaid Plan Owes \$701 Million to Providers, Vendors. *NPR/WBEZ Chicago* reported on June 27, 2019, that Cook County officials are questioning why Medicaid managed care plan CountyCare owes \$701 million to doctors, hospitals, and other vendors. The backlog at CountyCare, which is owned by Cook County Health, was revealed in a report from County Inspector General Patrick Blanchard. [Read More](#)

Iowa

Iowa, Medicaid Plans Continue to Negotiate Fiscal 2020 Payment Rates. *The Des Moines Register* reported on June 30, 2019, that Iowa is still in negotiations with Medicaid managed care plans over payment rates for fiscal year 2020. Medicaid Director Mike Randol said the parties are close to an agreement. Last year, plans received an 8.4 percent increase. [Read More](#)

Auditor Asserts Medicaid Plans Improperly Reduced Care to Two Quadriplegics. *The Waterloo-Cedar Falls Courier* reported on June 27, 2019, that Iowa auditor Rob Sand has accused the state's two Medicaid managed care

plans of improperly reducing care for two quadriplegic members. Sand outlined the claim in a letter to the Iowa Department of Human Services, which he says raises “serious concerns” about the program at large. Medicaid plans operating in Iowa are Amerigroup Iowa and UnitedHealthcare. [Read More](#)

Kansas

Kansas Expands Medicaid Services for Brain Injuries. *The Kansas City Star* reported on July 1, 2019, that Kansas has expanded Medicaid coverage for brain injuries to include “acquired brain injury,” e.g., brain injuries from tumors, strokes, and asthma attacks. It will also offer coverage to individuals under age 16. Previously, coverage only applied to people from age 16 to 65 with “traumatic brain injury,” e.g., injuries from a blow to the head. The coverage is provided through a Medicaid waiver dating to 1986. [Read More](#)

Louisiana

Medicaid MCO Awards Are Delayed. The Louisiana Department of Health announced on July 10, 2019, that the “procurement process is still ongoing” for the state’s pending Medicaid managed care contract awards. The awards were expected to be announced on July 8, delayed from an original date of June 28. [Read More](#)

Louisiana Medicaid Disenrolls Another 11,500 Members For Failing to Prove Eligibility. *The Associated Press/U.S. News* reported on July 1, 2019, that Louisiana disenrolled 11,500 Medicaid beneficiaries on June 30 for failing to prove their eligibility. More than 30,000 lost coverage March 30 as a result of the state’s new quarterly Medicaid eligibility check. [Read More](#)

Maine

Maine Enacts Law Aimed at Curbing Prescription Drug Costs. On June 24, 2019, Maine Governor Janet Mills signed into law a package of bills aimed at helping to curb prescription drug costs in the state. The legislation allows the wholesale importation of prescription medicine, creates a prescription drug affordability board, increases drug price transparency, and increases regulation of pharmacy benefit managers. [Read More](#)

Michigan

Michigan to End Medicaid Contract with Lakeshore Mental Health Agency; Beacon to Get Temporary Pact. *Crain’s Detroit Business* reported on July 1, 2019, that Michigan will terminate its Medicaid contract with Lakeshore Regional Entity, a community mental health agency that has been cited by the state for poor performance and years of financial deficits. The Michigan Department of Health and Human Services will sign a temporary contract with Beacon Health Options. [Read More](#)

New Hampshire

Governor to Sign Bill Protecting Coverage for Individuals with Pre-existing Conditions. *NHPR* reported on June 9, 2019, that New Hampshire Governor Chris Sununu announced his intent to sign Senate Bill 4, which would protect health coverage for people with pre-existing conditions. The announcement was made on the same day a panel of federal appellate judges heard oral arguments in a case that could decide the future of the Affordable Care Act. [Read More](#)

New Hampshire Announces Delay of Medicaid Expansion Work Requirements. *The Associated Press* reported on July 9, 2019, that New Hampshire has delayed the implementation of Medicaid expansion work requirements until the end of September. The decision comes after 17,000 people failed to report their employment status or request an exemption, putting them at risk of losing coverage. The implementation delay will give the state Department of Employment Security more time to ramp up outreach efforts. The program began in June. [Read More](#)

Medicaid Beneficiaries Numbering 20,000 Fail to Report Work Status. *The Concord Monitor* reported on July 6, 2019, that 20,000 Medicaid beneficiaries had failed to report their employment status or log an exemption, putting them at risk of losing coverage under the state's newly implemented work requirement. State regulators have the option of suspending the program to allow more time to contact beneficiaries who may be affected under a new law passed last month. The program began June 1. [Read More](#)

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

New Jersey Announces New Medicaid Director. On July 9, 2019, the New Jersey Department of Human Services Commissioner Carole Johnson announced that Jennifer Langer Jacobs will join New Jersey Medicaid as its new director. Jacobs will lead the Division of Medical Assistance and Health Services (DMAHS) to run the \$14 billion program, New Jersey FamilyCare which serves 1.7 million state residents. Jacobs comes to the position from Sunshine Health, a Florida-based Medicaid long-term care plan where she served as Senior Vice President of Long-Term Care. Before that Jacobs worked at Amerigroup New Jersey. She will join DMAHS beginning July 22, 2019.

New Jersey Launches Internet Registry For Psychiatric Advanced Directives. On June 27, 2019, the New Jersey Department of Human Services, Division of Mental Health and Addiction Services launched a secure online registry for consumers to express their choices about their mental health care during a personal mental health crisis. The registry establishes a confidential Psychiatric Advanced Directive (NJPAD) accessible 24/7 by consumers and certain mental health providers. NJPAD replaces a paper process. [Read More](#)

Governor Vetoes Increase in Personal Care Reimbursement Rate to \$20 Per Hour; Calls for Compromise to \$18 Per Hour. *NJ Spotlight* reported on July 3, 2019, that New Jersey Governor Phil Murphy issued a conditional veto on a bill that would raise Medicaid reimbursement for personal care services to \$20 per hour starting this week. The legislation, which was passed by both New Jersey Houses, would incrementally increase reimbursements to \$25 by 2025. Murphy is urging lawmakers to amend the bill to \$18 per hour, which he noted is supported by the fiscal year 2020 budget. [Read More](#)

New York

HMA Roundup - Denise Soffel ([Email Denise](#))

New York Re-Issues Request for Applications for Environmental Health Intervention. The New York State Department of Health has re-issued a Request for Applications (RFA) to solicit applications to participate in the Healthy Neighborhoods Program (HNP). The HNP is designed to provide preventive environmental health services to targeted geographic areas. These areas sometimes include environmental justice communities and are usually home to at-risk populations including low-income and often minority families, living in homes and neighborhoods with a disproportionate number of residential hazards. The “Healthy Neighborhoods Preventive Health Cornerstones” will provide funding in targeted areas to provide a healthier home. To address the environmental health needs in these neighborhoods, the grant funds are to be used to implement a HNP, with emphasis on reducing residential injuries, childhood lead poisoning, hospitalizations due to asthma, and exposure to indoor air pollutants. The total anticipated funding available for distribution is \$3,920,052 annually. Funding is limited to full-service county and city health departments with qualified environmental health staff. It is anticipated that 15-20 contracts will be awarded as a result of this RFA. Contracts will be issued for a five-year cycle (April 1, 2020 – March 31, 2025) with annual budgets and workplans required. Applications are due September 13, 2019. [Read More](#)

New York Posts Duals Demonstration Phase-Out Plan. The New York Department of Health has posted its phase-out plan for the Fully Integrated Dual Advantage (FIDA) program. FIDA was part of the federal duals demonstration initiative that began in 2014; FIDA will end on December 31, 2019. All FIDA enrollees will be transitioned to the Medicaid Advantage Plus plan affiliated with their current FIDA plan, unless they choose a different option. The phase-out plan has been posted for public comment, through July 22. [Read More](#)

New York Medicaid Redesign Team Waiver Public Comment Forum. The New York Department of Health hosted a public forum on June 24, 2019, addressing the state’s Medicaid program, operated under a Section 1115 waiver. The 1115 waiver, also known as the Medicaid Redesign Team (MRT) Waiver, is an agreement between the Centers for Medicare & Medicaid Services (CMS) and New York that allows the state to operate a mandatory Medicaid managed care program. The waiver is also the vehicle by which the state has implemented the initiatives of the Medicaid Redesign Team and subsequent health systems reform, including the Delivery System Reform Incentive Payment (DSRIP) program.

Prior to opening the session to public comments, staff provided an overview of the current waiver, and described several pending and planned amendments to the waiver. These include:

- Children’s System Transformation, which will move children currently served through waiver programs into mainstream Medicaid managed care, add home and community-based services currently provided through the children’s waiver into the mainstream benefit package, and authorize the enrollment of children in foster care.
- OPWDD reform and redesign to move people currently served through the Office for People with Developmental Disabilities into managed care.
- Managed Long Term Care (MLTC) nursing home carve-out to restrict MLTC enrollment to individuals not residing permanently in a nursing facility.
- Managed Long Term Care lock-in to limit MLTC enrollees’ ability to switch MLTC plans during their first year of enrollment.
- DSRIP extension post: March 2020
- Criminal justice waiver to provide Medicaid benefits to certain high-risk incarcerated individuals 30 days prior to release
- Supportive housing (Section 1915(i) waiver) to achieve federal financial participation in supportive housing.

The MRT Waiver presentation can be found on the [MRT website](#). The webcast of the meeting is available [here](#).

New York Holds Quarterly Medicaid Managed Care Advisory Review Panel Meeting. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for New York’s Medicaid managed care program, held its quarterly meeting on June 20, 2019. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the New York State Department of Health, provided a program update. The meeting included updates on behavioral health, managed long-term care, and results of a member satisfaction survey for Health and Recovery Plan members. The meeting also included a behavioral health update that addressed both the children’s behavioral health transition, the adult behavioral health program, and health homes; a status report on Managed Long Term Care; and a presentation about the 21st Century Cures Act and enrollment of providers into Medicaid.

Program Update

- The state is in the early stages of reviewing a proposal by Centene to acquire Wellcare. Wellcare has just over 100,000 Medicaid managed care enrollees in New York.
- HealthFirst has submitted an asset purchase agreement to acquire Medicaid and Essential Plan members from Crystal Run. Crystal Run Healthcare is a large multispecialty group practice in Sullivan and Orange Counties that began operating a Medicaid managed care plan in 2016. They currently have 1,600 Medicaid enrollees. HealthFirst, with a membership of over 930,000, does not currently operate in Sullivan or Orange counties.
- YourCare has applied to expand to an additional five counties: Genesee, Livingston, Orleans, Seneca and Wayne. Their application is awaiting approval from the Department of Financial Services. YourCare, with

37,000 members, is based in Rochester and currently operates in 7 counties in the western part of the state.

- VNS Choice has applied to expand its HIV Special Needs Plan to Nassau and Westchester. Currently HIV SNPs only operate in New York City.
- Three entities have applied to become certified as full mainstream Medicaid managed care plans. They are all currently operating managed long-term care plans and are interested in expanding into the mainstream Medicaid managed care market so they can participate in the state's Specialized I/DD plan offering, likely to begin in 2019. One plan, Partners Health Plan, has been conditionally certified as a mainstream plan. It is awaiting CMS approval before it can begin enrollment. The other two plans, Hamaspiik and ICircle Prime, are undergoing program and financial review.

New York Expands Telepsychiatry Regulations. The New York State Office of Mental Health announced on July 9, 2019, the adoption of new, expanded telepsychiatry regulations to give New Yorkers greater access to a range of mental health services using electronic communication. The new regulations allow more mental health practitioners to utilize virtual technology to provide or support clinical psychiatric care at a distance. Previous regulations only permitted psychiatrists and psychiatric nurse practitioners to utilize the technology. Telemental health will now be permitted at more hub locations, including a practitioner's home office and private practice settings. The regulations also expand the originating site to be anywhere the client is located within the state. Additionally, the regulations add Assertive Community Treatment and Personalized Recovery-Oriented Service sites as eligible treatment settings. [Read More](#)

Advocacy Groups to Co-Sponsor Webinar Exploring NYC Care. Medicaid Matters New York and Health Care for All New York, two leading consumer advocacy groups in New York, are co-sponsoring a webinar on New York City's Guaranteed Care Plan. The plan consists of the NYC Care program and NYC's Public Option. NYC Care is a program aimed at providing access to health care for residents of New York City who are unable to afford health care coverage or who are ineligible for coverage. The program will launch in the Bronx in August. The webinar will describe the NYC Care program being administered by NYC Health + Hospitals, and will discuss the benefits of the program, and the enrollment, community engagement, and outreach processes. The webinar will be held on July 17 from 1-2 PM. Click [here](#) for more information.

New York Moves to Per Member Per Month Reimbursement for Consumer Directed Personal Care Fiscal Intermediaries. On July 1, 2019, the New York Department of Health (DoH) has released a guidance related to the implementation of a new reimbursement structure for Fiscal Intermediaries (FI) working in the Consumer Directed Personal Assistance Program (CDPAP). As part of this year's budget, reimbursement for administrative services performed by FIs was changed from an hourly basis to a per member per month formula. The budget also imposes a plan to establish a selection process to reduce the number of FIs operating across the state. These changes come with a savings of \$75 million in each of the next two years. DoH is moving forward with the change in reimbursement effective September 2019. Guidance on the changes indicates that the FI PMPM would range from \$64 for clients receiving less than 160 hours of care per month (less than 5 hours of care per

day) to \$522 for clients receiving between 480 and 700 hours of care per month (15 – 24 hours of care per day). The chairs of both the Assembly and the Senate Health Committees have asked that the state delay the implementation of the PMPM changes until at least January 1, 2020 to “provide adequate time for a well-considered, open and seamless process that will ensure the safe, orderly and successful transition to the new CDPAP reimbursement model.” Advocates for the CDPA program argue that the change from an hourly reimbursement rate to a PMPM is effectively a rate cut that will force many FIs to close and will put the CDPA program and its beneficiaries in jeopardy. The guidance also establishes transition processes and procedures to ensure an orderly transition of consumers to a different Fiscal Intermediary in the event an FI chooses to cease operations, which include continuity of care and other consumer protections.

New York Stony Brook University Medicine Acquires Eastern Long Island Hospital. Eastern Long Island Hospital (ELIH) announced on July 1, 2019, that it has officially joined New York’s Stony Brook University Medicine healthcare system. Stony Brook University Medicine, part of the State University of New York (SUNY) system, operates the 603-bed University Hospital. ELIH will now be referred to as Stony Brook Eastern Long Island Hospital (SBELIH). Eastern Long Island Hospital first announced plans to join Stony Brook in 2015, linking it to a major tertiary hospital with access to greater financial, clinical and academic resources. The deal was delayed by the need for approvals from the state Departments of Health and Budget as well as the state attorney general and comptroller. The state was skittish to allow a SUNY hospital to acquire a smaller community hospital after SUNY Downstate Medical Center’s short-lived and costly acquisition of Long Island College Hospital in Brooklyn, which cost the state millions. Stony Brook has committed to keeping ELIH open and maintaining its existing services. The 125-bed Southampton Hospital joined the Stony Brook system in August 2017. [Read More](#)

North Carolina

North Carolina Could Delay Medicaid Managed Care Implementation if State Budget is Not Signed. *The Winston-Salem Journal* reported on July 8, 2019, that if North Carolina Republicans fail to override Democratic Governor Roy Cooper’s budget veto, the state could delay its transition to Medicaid managed care at least until March. If the budget is not signed by July 15, implementation would be delayed because of an amendment to Senate Bill 212 added June 27. Separately, a bipartisan Medicaid expansion bill (House Bill 655) has also resurfaced. [Read More](#)

Judge Denies Temporary Injunctions to Halt Medicaid Managed Care Transition. *The North Carolina Health News* reported on July 3, 2019, that a North Carolina administrative judge denied a request for a preliminary injunction from three health plans seeking to temporarily stop the state’s transition to Medicaid managed care. Lawsuits filed by Aetna, Optima, and My Health by Health Providers claimed they were unfairly passed over for contracts. The three plans are expected to appeal the decision. [Read More](#)

Ohio

Beaumont Health to Acquire OH-Based Summa Health. *The Detroit Free Press* reported on July 9, 2019, that Beaumont Health, Michigan's largest health care system, has signed a letter of intent to acquire Ohio-based not-for-profit Summa Health. Under the terms of the deal, Summa would become a subsidiary of Beaumont. The deal, which would represent Beaumont's first out-of-state venture, is expected to be finalized by the end of 2019. [Read More](#)

Health System MetroHealth to Invest \$60 Million in Housing, Job Training, Other Social Services. *Modern Healthcare* reported on June 28, 2019, that Cleveland-based MetroHealth announced plans to invest \$60 million in housing, job training, and other social services for the local community. The initiative will include construction of 250 new apartments for residents who earn 30 to 80 percent of the area's median income. [Read More](#)

Oklahoma

Oklahoma Is Asked to Give CMS Part of Opioid Settlement. *The New York Times* reported on June 27, 2019, that the Centers for Medicare & Medicaid Services (CMS) is seeking a portion of the \$270 million opioid settlement between Purdue Pharma and the state of Oklahoma. CMS warned the state that failure to turn over a portion of the settlement could result in the withholding of federal Medicaid funds. [Read More](#)

Oregon

Oregon Announces CCO 2.0 Contract Awards. On July 9, 2019, the Oregon Health Authority announced the awards for the Oregon Health Plan CCO 2.0 Medicaid program, worth \$6 billion for the 2020 contract year. A total of 15 coordinated care organizations (CCOs) were awarded contracts – 11 CCOs for five-year contracts and four for one-year contracts:

- AllCare CCO, Inc.: 1 year
- Cascade Health Alliance: 1 year
- Columbia Pacific CCO, LLC: 5 years
- Eastern Oregon Coordinated Care Organization LLC: 5 years
- Health Share of Oregon: 5 years
- InterCommunity Health Network Coordinated Care Organization: 5 years
- Jackson Care Connect: 5 years
- PacificSource Community Solutions – Central Oregon: 5 years
- PacificSource Community Solutions – Columbia Gorge: 5 years
- PacificSource Community Solutions – Lane: 5 years
- PacificSource Community Solutions – Marion Polk: 5 years
- Trillium Community Health Plan Inc.: 5 years
- Umpqua Health Alliance, LLC: 1 year
- Western Oregon Advanced Health, LLC: 5 years
- Yamhill County Care Organization: 1 year

Incumbent PrimaryHealth was the only current CCO that did not win a new contract. Incumbent Willamette Valley Community Health (WVCH) did not seek a new contract. Three new applicants also did not win. Oregon CCOs serve approximately 1 million members. [Read More](#)

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

Pennsylvania Passes Budget Bill. *The Pittsburgh Post-Gazette* reported on July 28, 2019, that Pennsylvania Governor Tom Wolf signed the state's \$34 billion budget. The fiscal year, which began July 1, does not increase tax rates on sales or income, the state's two biggest sources of revenue. It boosts funding for public schools, state-run universities, and community colleges and sets money aside for the state's main savings account. It also includes \$16 million for the Medicaid Day One Incentive (MDOI) program. Designed to aid nursing homes with at least 65 percent Medicaid residents, the program received \$8 million annually since 2013. The local increase is also expected to trigger an additional \$17 million in federal match funds for Pennsylvania nursing homes. The prominent priorities that the administration was unable to secure were raising the \$7.25 per-hour minimum wage, saving a cash assistance program for the poor or passing a new tax on natural gas drillers. However, authorization was granted for the administration to take over Pennsylvania's online health insurance exchange. [Read More](#)

Pennsylvania Moves to Implement State-Based Health Insurance Exchange. On July 2, 2019, Pennsylvania Governor Tom Wolf signed House Bill 3 into law that provides the authority to implement a state-based marketplace, to be called the Pennsylvania Health Insurance Exchange Fund. The state-based marketplace, in conjunction with a federal waiver, will also enable a new re-insurance program that will significantly lower premiums for those who purchase their health insurance through the individual market. The state-based exchange is expected to be operational as early as January 1, 2021. [Read More](#)

Pennsylvania eHealth Partnership Program Continues to Expand. On July 2, 2019, the Pennsylvania Department of Human Services (DHS) Pennsylvania eHealth Partnership Program announced that Central Pennsylvania Connect Health Information Exchange is now connected to the PA Patient & Provider Network (P3N). Central PA Connect is one of five active health information organizations (HIOs) in Pennsylvania. With the addition of Central PA Connect, all five currently existing HIOs are connected to the P3N statewide. [Read More](#)

Pennsylvania Delays MATP Changes. *The Wayne Independent* reported on July 3, 2019, that Pennsylvania postponed a change to the Medical Assistance Transportation Program (MATP) via Senate Bill 695. SB 695 calls for a brokerage implementation review to investigate the impact on rural communities. Last year, the Pennsylvania Department of Human Services (DHS) received a legislative mandate to restructure the MATP system such that a regional statewide broker would manage it instead of a local operator. The review, required by SB 695, will analyze the current program, examine consumer impact, and weigh impact of switching to a state-wide brokerage model. A preliminary analysis is expected to be completed in 90 days with the full report due in December. [Read More](#)

Pennsylvania Hires Temporary Manager for Hahnemann University Hospital. *GlobeSt.com* reported on July 8, 2019, that the Pennsylvania Department of Health and the Pennsylvania Academic Health System (PAHS) have agreed to the placement of a temporary manager at PAHS's Hahnemann University Hospital and St. Christopher's Hospital for Children. News of Hahnemann's intent to close came in late June, prompting a cease and desist order from the state, requiring the hospital and its emergency room to remain open. The temporary manager, Pinnacle Healthcare Consulting, will remain in place until the department determines it is no longer necessary. [Read More](#)

University Health System Files for Chapter 11 Bankruptcy. *PhillyVoice* reported on July 1, 2019, that Philadelphia Academic Health System, the owner of both St Christopher's Hospital for Children and Hahnemann University Hospital, has filed for Chapter 11 bankruptcy protection and announced plans to close this fall. Hahnemann has also announced it will no longer accept trauma patients. The Pennsylvania Health Department issued a cease-and-desist letter requiring state approval for a closure plan before closing or eliminating services. Drexel University, who used the hospital as its teaching hospital, filed a lawsuit in an attempt to prevent the closure. [Read More](#)

Puerto Rico

Former Health Insurance Administration Director Faces Fraud Charges. *Noticel* reported on July 10, 2019, that Puerto Rico's former Health Insurance Administration (ASES) director faces charges of conspiracy to commit fraud against the U.S. Government, among other charges. Ángela Ávila Marrero oversaw the island's Medicaid program. Also facing charges are executives of accounting firm BDO Puerto Rico. [Read More](#)

Texas

Texas Delays STAR+PLUS Implementation. On July 9, 2019, the Texas Health and Human Services Commission (HHSC) announced that the new contracts for the STAR+PLUS managed care services program will be delayed until September 1, 2020. Awards are expected around August 30, 2019. STAR+PLUS serves about 526,000 aged, blind, and disabled members.

Washington

Washington Public Option May Be Less Impactful After Political Compromises. *The New York Times* reported on June 27, 2019, that the public health insurance option enacted in Washington state was watered down by compromises likely to make it less impactful than supporters had hoped. Participation in the plan's network is optional for providers, and while the law allows the state to regulate some health care prices, those prices were set significantly higher than the law's supporters wanted. [Read More](#)

West Virginia

West Virginia Releases Managed Foster Care RFP. On July 1, 2019, the West Virginia Department of Health and Human Resources released a request for proposals (RFP) to provide physical and behavioral managed care services for approximately 18,300 children and youth in foster care or receiving adoption assistance. Implementation is scheduled to begin January 1, 2020, with the contract running through June 30, 2020, with three optional one-year renewals. Only one Medicaid managed care organization will be selected. Currently, foster care services are fee-for-service.

National

CMS Prior Authorization Change Improves Access to Medication-Assisted Treatment, Study Shows. *Modern Healthcare* reported on July 9, 2019, that a federal rule change has increased access to medication-assisted treatment (MAT) by reducing prior authorization barriers for Medicare members struggling with opioid addiction, according to a study published in [JAMA](#). The study recommends CMS issues similar guidance for Medicaid and private health plans. [Read More](#)

Trump Signs Order Aimed at Improving Care for Kidney Disease. *The New York Times* reported on July 10, 2019, that President Trump signed an executive order aimed at improving kidney care by increasing the supply of donated kidneys and prioritizing in-home dialysis. The administration will also try to ease the financial burden for live donors by reimbursing expenses like lost wages and childcare. [Read More](#)

Working Parents of Most Children on Medicaid, CHIP Are Employed by Large, Private Companies, Report Says. *WUSF News* reported on July 9, 2019, that the vast majority of children from working families covered by Medicaid or the Children's Health Insurance Program (CHIP) have a parent working for a large, private company, new research shows. The findings from the PolicyLab at Children's Hospital of Philadelphia suggest that employer-sponsored healthcare can be too expensive for some low-income families and using public insurance is a better option. The report also shows that between 2008 and 2016, the rate of children from low- and moderate- income working families covered by public insurance has increased at a significant rate. [Read More](#)

Vast Majority of Hospices Violated at Least One Medicare Safety Requirement, OIG Finds. *Modern Healthcare* reported on July 9, 2019, that 87 percent of 4,563 hospice providers violated at least one safety requirement for Medicare participation over five years through 2016, according to the U.S. Office of the Inspector General (OIG). Common violations included poor care planning, mismanagement of aide services, and inadequate assessments of beneficiaries. OIG recommends included publication of deficiency data and additional education and support to hospice facilities with a history of serious violations. CMS agreed with the suggestions. [Read More](#)

Trump to Issue Executive Order Pegging Drug Prices to Lowest Amount Paid by Other Nations, Companies. *The Associated Press* reported on July 5, 2019, that President Trump has promised to issue an executive order aimed at ensuring that the U.S. government doesn't pay more than other nations or companies for prescription drugs. Trump said his administration is working on a "favored-nations clause." No other details were available. [Read More](#)

Appellate Court Will Hear Oral Arguments On ACA Beginning July 9. *The Hill* reported on July 7, 2019, that a federal appeals court will begin to hear oral arguments over the constitutionality of the Affordable Care Act (ACA) on July 9. In December, a federal Judge in Texas struck down the ACA, ruling that the law was rendered invalid after Congress eliminated the penalty for not having health insurance. A panel of three judges will hear the case, including two appointed by Republican presidents and one by a Democratic president. [Read More](#)

Appellate Court Refuses Request to Postpone ACA Hearing. *Modern Healthcare* reported on July 2, 2019, that a federal appeals court rejected a request to delay a hearing on the constitutionality of the Affordable Care Act (ACA). The 5th U.S. Circuit Court of Appeals gave a two-day extension for Republican states opposing the law to file their requested briefs, but wouldn't delay oral arguments that are scheduled for July 9. [Read More](#)

Some Plans to Pay Hundreds of Millions of Dollars Into ACA Risk-Adjustment Program. *Modern Healthcare* reported on July 1, 2019, that some health plans will need to pay hundreds of millions of dollars into the Affordable Care Act risk-adjustment program, which is meant to help stabilize premiums for health insurance coverage offered through the Exchanges. Among the highest payers are Kaiser Permanente, Centene, and Molina, which must pay \$891.7 million, \$629.7 million, and \$373.2 million, respectively, for 2018. Some smaller new entrants must also make high payments. Oscar, for example, must pay \$201.9 million to the individual market's risk-adjustment program. Meanwhile, plans set to receive the largest payments included Blue Shield of California, Health Care Service Corp., and Blue Cross Blue Shield of Florida. [Read More](#)

Nursing Home Staffing Regularly Falls Below CMS Expectations, Study Finds. *Modern Healthcare* reported on July 1, 2019, that nursing home staffing levels are less than what the Centers for Medicare & Medicaid Services (CMS) expects on the majority of days and especially on weekends, according to a new study published in *Health Affairs*. The data showed particular shortfalls for registered nurses, with most facilities meeting expectations less than 60 percent of the time. [Read More](#)

CMS Says ACA Risk-Adjustment Program Is Working As It Should. *Modern Healthcare* reported on June 28, 2019, that the Centers for Medicare & Medicaid Services (CMS) released 2018 data on the performance of the Affordable Care Act risk-adjustment program, which is meant to help stabilize premiums for health insurance coverage offered through the Exchanges. CMS concluded that the risk-adjustment program is working as it should by redistributing financial resources according to the relative risk of the populations covered by participating health plans. [Read More](#)

House Democrats Investigate Trump Administration Efforts to Change Medicaid. *The Hill* reported on June 27, 2019, that House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) has launched an investigation into efforts by the Trump administration to convince states to change their Medicaid programs. The administration has been advocating initiatives like block grants and per capita caps. [Read More](#)

Appellate Court Questions If States, House Have Standing to Defend ACA. *Politico* reported on June 26, 2019, that a federal appeals court is questioning whether states and the U.S. House of Representatives have standing to appeal a federal judge's ruling that struck down the Affordable Care Act. The 5th U.S. Circuit Court of Appeals is scheduled to hear oral arguments in July. [Read More](#)

Senate Health Committee Advances Bills to End Surprise Medical Bills, Lower Drug Costs. *The New York Times* reported on June 26, 2019, that the Senate health committee approved legislation aimed at ending surprise medical bills, increasing transparency in medical billing, and curbing prescription drug prices. The package also includes a bill from Senate Majority Leader Mitch McConnell (R-KY) to raise the smoking age in every state to 21. [Read More](#)

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Strategies for Connecting Justice Involved Populations to SUD Treatment. On July 30th from 2:30 PM - 3:30 PM EST, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program's (IAP) Reducing Substance Use Disorder (SUD) program area is holding a national webinar on strategies to connect justice involved individuals to SUD treatment. In this webinar, participants will learn about the high prevalence of substance use disorders in the justice involved population and the intersection of Medicaid in this population. Speakers from Arizona Health Care Cost Containment System (AHCCCS) will share strategies the state has used to successfully connect the justice involved population to SUD treatment, including the use of automated data exchanges to suspend and reinstate Medicaid enrollment; care coordination by managed care organizations and regional behavioral health authorities; and the development of justice involved targeted investment programs. HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates. To participate in this webinar, register [here](#).



INDUSTRY NEWS

Hospital, Insurer Acquisitions of Medical Groups Face Increased Regulatory Scrutiny. *Modern Healthcare* reported on July 6, 2019, that acquisitions of physician groups by insurers, hospitals, and private equity firms face increased regulatory scrutiny as concerns over industry consolidation and health care costs grow. Several deals have been blocked or approved only with certain conditions. Most of the deals involve vertical integration. [Read More](#)

Senior Care Provider ClareMedica Receives Investment from Beecken Petty O’Keefe & Company. Florida-based ClareMedica Health Partners announced on July 1, 2019, that it has received a majority equity investment from private equity firm Beecken Petty O’Keefe & Company. ClareMedica, which delivers primary care to seniors, expects to use the funds for practice acquisitions. Financial terms were not disclosed. [Read More](#)

HCA Healthcare Completes Acquisition of TX Urgent Care Centers. HCA Healthcare announced on July 1, 2019, that it has completed the acquisition of 24 MedSpring urgent care centers in Austin, Dallas, and Houston, TX, from Fresenius Medical Care. The MedSpring urgent care centers will be rebranded as CareNow Urgent Care, which represents the largest urgent care network in the country. Terms of the agreement were not disclosed. [Read More](#)

Community Health Systems Finds Buyer for Bluefield Regional Medical Center in West Virginia. Community Health Systems announced on June 27, 2019, a definitive agreement to sell Bluefield Regional Medical Center in West Virginia to subsidiaries of Princeton Community Hospital. The transaction, which will include other Bluefield healthcare operations, is expected to close in the third quarter of 2019. Bluefield is among the assets Community Health Systems had previously targeted for divestiture. [Read More](#)

Sanford Health, UnityPoint Health Announce Merger. *Modern Healthcare* reported on June 28, 2019, that Sanford Health and Iowa-based UnityPoint Health have agreed to merge, a transaction that will create an \$11 billion integrated healthcare system with 76 hospitals in 26 states. The deal, which is expected to be completed by the end of 2019, requires regulatory approval. [Read More](#)

Providence St. Joseph Health to Acquire Bluetree Network. *Modern Healthcare* reported on June 27, 2019, that Washington-based Providence St. Joseph Health will acquire Bluetree Network Inc., which provides consulting and support services to organizations using Epic electronic health records. Terms weren’t disclosed. [Read More](#)

Magellan Health Considers Sale to Private Equity Firm Centerbridge. *The Wall Street Journal* reported on June 26, 2019, that private-equity firm Centerbridge Partners LP is in talks to buy Magellan Health, which has a market capitalization of about \$1.6 billion. Centerbridge may consider selling off Magellan assets, such as its pharmacy benefit management business, which accounts for one-third of company revenue. An agreement could be reached as early as next month. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
July 2019	Louisiana	Awards	1,500,000
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 2019	Ohio	RFI #2 Release	2,360,000
August 30, 2019	Texas STAR+PLUS	Awards	530,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
September 1, 2019	New Hampshire	Implementation	181,380
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Implementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January - March 2020	Ohio	RFP Release	2,360,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
January 1, 2020	Washington Integrated Managed Care - Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum Counties); Salish (Clallam, Jefferson, and Kitsap Counties); Thurston-Mason (Mason and Thurston Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	315,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	960,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	148,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	265,500
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

HMA WELCOMES

Tim Sheehan - Principal

A seasoned leader with experience establishing strategic and effective partnerships, Tim Sheehan has developed and led programs to improve performance for Medicaid, mental health, opioid, managed care and other healthcare relationships and programs.

Before joining HMA, Tim spent nearly three decades with Lutheran Social Services of Illinois where he served in various roles including vice president of home and community services. The organization serves more than 60,000 clients with home care, senior housing, prison ministry, child welfare, developmental disabilities (DD), substance use and mental health services.

His work included collaborating on a Medicare Advantage Care Management model to spur individuals to access social determinants of health resources at a local level. He also oversaw development of performance-based contracts with managed care organizations, including use of bundled rates, which resulted in contracts yielding significant financial return and improved member care. Tim also contracted with CountyCare and partnered with five care management entities to create an integrated discharge and follow up to hospitalization pilot.

In addition to crafting and implementing projects, he partnered with statewide trade organizations and corporate partners to develop a behavioral health pathway to obtain value-based agreements by contracting beyond the limits of a single organization. Most recently, he helped develop the first behavioral health Independent Practice Alliance in Illinois

A true advocate for those in need, he also provided substance use disorder support, overseeing implementation of a medication assisted detoxification center, part of a medication assisted treatment strategy for local emergency rooms. Tim and his team developed five, 24/7 hospital emergency room diversion programs and a mobile crisis component to complement this cluster of programs to lower inpatient mental health admissions.

With a Master of Social Work from Loyola University, Chicago and a bachelor's degree in psychology, Tim has worked diligently over his career to improve the well-being of the clients he has served.

He has served on the board of directors for the Community Behavioral Health Association (CBHA) where he was part of the team that passed five laws benefiting care to individuals with behavioral health conditions. He also served in Public Policy for CBHA for eight years.

Tony Whelan - Senior Consultant

Tony Whelan is a financial healthcare expert with nearly 20 years' experience leading healthcare financing and regulatory efforts. Throughout his career he has enhanced his knowledge and honed his skills related to healthcare management, financial analysis, reimbursement, consulting and auditing for clients and partners.

Tony's scope of service includes cost reports for a wide range of facilities, including acute care hospitals, home offices and rural health clinics as well as contractual adjustments, uncompensated care payments, cost report re-opening and appeal request, and hospital consolidation analysis.

Prior to joining HMA, Tony spent two years with RSM and nine years at PricewaterhouseCoopers (PWC), where his client-focused approach to reimbursement-related issues included cost report preparation and review, provider number analysis, due diligence, Medicare wage index and occupational mix reviews, third party settlements and reserve analysis, and Medicare appeals and contractual allowance reviews.

Tony's efforts were not focused solely on processes, but also on innovation, developing models to assist clients with evaluation and financial analysis or opportunities, and issues related to Medicare/Medicaid provider changes specifically involving analysis or reimbursement.

Before working with PwC, he was instrumental in preparing presentations for formal adversarial proceedings before the Centers for Medicare and Medicaid Solutions, Provider Reimbursement Review Board (PRRB). This work, done while he was a consultant with the BlueCross BlueShield Association, included requests for hearings, filing jurisdictional determinations, drafting preliminary papers, review and analysis of final position papers and completing administrative resolutions on cases prior to board hearings. He also provided advisory assistance to plans on Medicare reimbursement issues and appeal procedures to ensure mandated appeal procedures were followed.

Tony earned a Master of Business Administration from Elmhurst College as well as a bachelor's degree in accounting and business administration from Carthage College.

HMA NEWS

Alan Weil of Health Affairs to Deliver Policy Keynote Address at HMA Conference in Chicago

Alan Weil, editor-in-chief of *Health Affairs*, will address *Medicaid and the Future of Health Care* in his policy keynote address at HMA's annual conference on publicly sponsored health care, September 9-10 in Chicago.

Weil will discuss the growing and changing role of Medicaid and how it is likely to impact the broader direction of health care in America for years to come. Weil will also address the political and regulatory environment impacting programs like Medicaid, including populist appeals for expansion, the controversies surrounding work requirements, and renewed efforts to incorporate community-based care, social determinants of health, behavioral health, substance-abuse treatment, wellness, and integrated care for high-cost aged, disabled, and chronically ill populations.

The title of the conference, which will be held at the Chicago Marriott Downtown Magnificent Mile, is *The Next Wave of Medicaid Growth and Opportunity: How Payers, Providers, and States Are Positioning Themselves for Success*. More than 300 high-level executives are already registered to attend, including representatives from health plans, providers, state and federal government, community-based organizations and others serving Medicaid. Total attendance is expected to top 450.

Visit conference.healthmanagement.com/ for complete details and to register, or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Arizona SNP Membership at 103,816, Mar-19 Data
- Hawaii SNP Membership at 22,883, Mar-19 Data
- Indiana SNP Membership at 22,768, Mar-19 Data
- Iowa SNP Membership at 12,162, Mar-19 Data
- Kansas SNP Membership at 4,162, Mar-19 Data
- Maine SNP Membership at 9,220, Mar-19 Data
- Montana SNP Membership at 761, Mar-19 Data
- North Dakota SNP Membership at 195, Mar-19 Data
- New York SNP Membership at 324,419, Mar-19 Data
- Pennsylvania SNP Membership at 151,075, Mar-19 Data
- Virginia SNP Membership at 49,865, Mar-19 Data
- Washington SNP Membership at 51,457, Mar-19 Data
- Wisconsin SNP Membership at 41,334, Mar-19 Data
- Mississippi Medicaid Managed Care Enrollment is Flat, Jun-19 Data
- North Carolina Medicaid Enrollment by Aid Category, Jun-19 Data
- Nevada Medicaid Managed Care Enrollment is Down 1.2%, May-19 Data
- New Mexico Medicaid Managed Care Enrollment is Flat, Jun-19 Data
- Oregon Medicaid Managed Care Enrollment is Down 2.6%, May-19 Data

- Virginia Medicaid MLTSS Enrollment is Over 242,500, Jun-19 Data
- Wisconsin Medicaid Fee for Service vs. Managed Care Penetration, 2014-18

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alabama Medicaid External Quality Review Organization (EQRO) Acquisition RFP, Jun-19
- California Automated Recovery Management (Cal-ARM) Draft RFP, Jun-19
- Connecticut Behavioral Health Program Contracts, 2011-20
- DC Medicaid Managed Care RFP, Proposals, Contracts, and Related Documents, 2018-19
- Indiana Pharmacy Benefit Management Services RFP and Award, 2018-19
- North Carolina Medicaid Managed Care Ombudsman Services RFP and Revisions, 2019
- New Mexico HHS 2020 Medicaid Enterprise Financial Services RFP, Jun-19
- Oregon Final CCO 2.0 RFA, Awards, Evaluations, and Related Documents, Jul-19
- Tennessee Medicaid Managed Care Contract, 2019
- Texas STAR+PLUS RFP Reissue, Delay Notice, and Related Documents, 2018-19
- West Virginia Managed Care for Children and Youth in Foster Care RFP, 2019
- West Virginia Medicaid External Quality Review Organization (EQRO) RFQ, Jun-19

Medicaid Program Reports, Data and Updates:

- Alaska Section 1115 Behavioral Health Waiver Overview Presentation, Apr-19
- Arkansas Monthly Enrollment and Expenditures Report, May-19
- CMS Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year, Jun-19
- Arizona AHCCCS at a Glance, Jun-19
- Arizona AHCCCS Population Demographics, Jul-19
- DC Medical Care Advisory Committee Meeting Materials, Jun-19
- Idaho Medicaid Healthy Connections Value Care Program Update, Jan-19
- Louisiana Department of Health Medicaid Expansion Dashboard, Jun-19
- North Carolina Medicaid Expenditures Near \$14.6 Billion, SFY 2018
- North Carolina Medicaid Managed Care Quality Strategy, Apr-19
- New Hampshire External Quality Review Organization (EQRO) Technical Report, SFY 2018
- New Hampshire Medicaid Care Management (MCM) Quality Strategy Reports, SFY 2019-20
- New Hampshire Medicaid Enrollment by Eligibility Group and County, May-19
- New Hampshire Medicaid Expansion Work Requirements Findings and Delay Letter, Jul-19
- New Hampshire Medical Care Advisory Committee Meeting Materials, May-19
- New Hampshire Quality Assurance and Improvement: Medicaid Care Management Quality Strategy Presentation, Jul-19
- New York FIDA Demonstration Phase-out Plan, Jun-19

- Pennsylvania Medical Assistance Advisory Committee (MAAC) Meeting Materials, Jun-19
- Wisconsin Medicaid MCO Actuarial Rate Certifications and Capitation Rates, 2018-19

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<http://healthmanagement.com/about-us/>

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